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Federal Register

Tuesday
June 3, 1986

Briefings on How To Use the Federal Register—
For information on briefings in Seattle, WA, and San Francisco, CA, see announcement on the inside cover of this issue.

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THE FEDERAL REGISTER: WHAT IT IS AND HOW TO USE IT

FOR: Any person who uses the Federal Register and Code of Federal Regulations.

WHO: The Office of the Federal Register.

WHAT: Free public briefings (approximately 2 1/2 hours) to present:

1. The regulatory process, with a focus on the Federal Register system and the public's role in the development of regulations.
2. The relationship between the Federal Register and Code of Federal Regulations.
3. The important elements of typical Federal Register documents.
4. An introduction to the finding aids of the FR/CFR system.

WHY: To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

SEATTLE, WA

WHEN: July 22; at 1:30 pm.

WHERE: North Auditorium, Fourth Floor, Federal Building, 915 2nd Avenue, Seattle, WA.

RESERVATIONS: Call the Portland Federal Information Center on the following local numbers:

Seattle	206-442-0570
Tacoma	206-383-5230
Portland	503-221-2222

SAN FRANCISCO, CA

WHEN: July 24; at 1:30 pm.

WHERE: Room 2007, Federal Building, 450 Golden Gate Avenue, San Francisco, CA.

RESERVATIONS: Call the San Francisco Federal Information Center, 415-556-6600

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Separate Parts In This Issue

Reader Aids
Additional information, including a list of public laws, telephone numbers, and finding aids, appears in the Reader Aids section at the end of this issue.

CFR PARTS AFFECTED IN THIS ISSUE

A cumulative list of the parts affected this month can be found in the Reader Aids section at the end of this issue.

Federal Register
Vol. 51, No. 106
Tuesday, June 3, 1986

Presidential Documents

Title 3—

The President

Proclamation 5496 of May 30, 1986

National Neighborhood Housing Services Week, 1986

By the President of the United States of America

A Proclamation

America's neighborhoods are made up of families representing a great variety of ethnic, social, and economic backgrounds. From this rich mix of cultures and experiences, a strong sense of cooperation and commitment has emerged that enhances our sense of the Nation as a larger family of people caring for one another. As we complete our preparations for the national celebration of the centennial of the Statue of Liberty this July 4, we are made even more aware of the special blessings, the strengths, and the virtues that flow from our long heritage of welcoming and drawing on the experiences of people from diverse backgrounds to make our free society ever more dynamic, cohesive, and productive.

When any neighborhood suffers from decline due to loss of business or other factors, all of its residents feel the pinch, but the elderly and the poor suffer most. Homes decline in value, economic growth stops, businesses relocate, and residents face real hardships. The Nation as a whole suffers, since thriving neighborhoods are the living cells of our national life. That is why it is so important to arrest the deterioration and revive the strength and vigor of America's neighborhoods.

Traditionally, Americans have recognized such problems and have worked together to develop practical solutions at the grass-roots level. Neighborhood Housing Services programs, which are partnerships made up of local residents, business leaders, and government officials, reflect this spirit and give scope to the ingenuity of the American people. Throughout the United States, Neighborhood Housing Services programs are working to revitalize more than 200 neighborhoods. Already, they have generated more than three billion dollars in reinvestment funds. Rather than looking to the Federal government for assistance, these programs have relied primarily on local and private resources and the help of hundreds of volunteers. These volunteers have contributed countless hours of work to help rebuild and revitalize neighborhoods.

The efforts and accomplishments of Neighborhood Housing Services programs have earned the respect and gratitude of all who recognize that local initiatives and self-reliance will always be the major factor in solving local problems. It is fitting and appropriate that their efforts be recognized by all Americans.

The Congress, by House Joint Resolution 492, has designated the week beginning June 1, 1986, as "National Neighborhood Housing Services Week" and authorized and requested the President to issue a proclamation in observance of this week.

NOW, THEREFORE, I, RONALD REAGAN, President of the United States of America, do hereby proclaim the week beginning June 1, 1986, as National Neighborhood Housing Services Week. I call upon local and State jurisdictions, appropriate Federal agencies, and the people of the United States to observe this week with appropriate ceremonies and activities.

IN WITNESS WHEREOF, I have hereunto set my hand this thirtieth day of May, in the year of our Lord nineteen hundred and eighty-six, and of the Independence of the United States of America the two hundred and tenth.

Ronald Reagan

[FR Doc. 86-12840
Filed 6-2-86; 11:09 am]
Billing code 3195-01-M

Presidential Documents

Proclamation 5497 of May 30, 1986

National Theatre Week, 1986

By the President of the United States of America

A Proclamation

Theatre is an ancient and honored art form with a recorded history spanning 2,500 years. Some have speculated that its roots go so deep in human nature and human experience that it may well be the wellspring of all the arts. We do know that poetry, story-telling, dance, music, masks, costumes, and sets all have a place in what we have come to call "theatre." These elements can be found in the performances of primitive tribes and the most sophisticated modern productions. In fact we see the impulse to theatre in every child who has ever played "let's pretend" or "make believe."

Theatre lets us stand apart from the flow of life: to feel pity and understanding and empathy; to smile at human foibles and to weep at human tragedies. Theatre is an art form for all seasons and all moods. It can refresh our spirits with comic hijinks, dazzle us with the splendor of pageantry, and impart rich insights into human relationships. It can convulse us into gales of laughter, wring our hearts with pathos, and dramatize eternal moral truths. In the works of such giants as Shakespeare, Goethe, Moliere, and O'Neill it can do all these things.

In one respect theatre is an art of the present moment—once performed it is gone, save in the memory of the audience. Yet new productions and performances give it a kind of ever-renewed immortality. It can put us in touch with the culture, conditions, and viewpoints of many civilizations. Indeed, theatre is at once a reminder and an affirmation of the continuity of civilization and the fundamental unity of all mankind.

That continuity is manifested not only in performances of plays of the past, but also in the attempts of modern artists to give voice to the conditions and experiences of our own time. These efforts, in turn, will enrich the legacy we will leave to future generations.

Today, theatre exists not only in the traditional cultural centers of our country but all across the land. Theatre at all levels—professional, community, and school—has sprung up in every region of our country. There is no greater testimony to mankind's need for theatre than this. Today we are experiencing a renaissance of the living theatre, with great gains in artistic excellence, in aesthetic variety and diversity of cultural voices—and in growing and loyal audiences throughout America.

In recognition of the importance of theatre in the lives of all Americans, the Congress, by Senate Joint Resolution 247, has authorized the President to proclaim the week of June 1 through June 7, 1986, as "National Theatre Week."

NOW, THEREFORE, I, RONALD REAGAN, President of the United States of America, do hereby proclaim the week beginning June 1, 1986, as National Theatre Week. I encourage the people of the United States to observe this month with appropriate ceremonies, performances, programs, and activities.

IN WITNESS WHEREOF, I have hereunto set my hand this thirtieth day of May, in the year of our Lord nineteen hundred and eighty-six, and of the Independence of the United States of America the two hundred and tenth.

Ronald Reagan

[FR Doc. 86-12641
Filed 6-2-86; 11:10 am]
Billing code 3195-01-M

Rules and Regulations

Federal Register
Vol. 51, No. 106
Tuesday, June 3, 1986

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 1136

Milk in the Great Basin Marketing Area; Order Suspending Certain Provisions

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Suspension of rule..

SUMMARY: This action continues a prior suspension of the provisions of the Great Basin milk order that limit the amount of milk not needed for fluid (bottling) use that may be moved directly from farms to nonpool manufacturing plants and still be priced under the order. Also continued is a suspension of the requirement that 6 days' production of each producer whose milk is diverted to nonpool plants be received at pool plants in order for the diverted milk to be priced and pooled under the order. The continuing action was requested by Western General Dairies, Inc., a cooperative association representing most of the producers supplying the market.

The suspension is based on information received at a public hearing held on March 18–20, 1986, in Salt Lake City, Utah. The hearing was held to consider a proposal to merge the Great Basin and Lake Mead milk orders. Provisions of the proposed merged order would alleviate the pooling problems experienced by the cooperative for approximately the past year. A further suspension of the order's diversion limits and "touch-base" requirement is warranted until the hearing proceeding has been completed.

Such interim action is needed to provide a continuation of the orderly and efficient handling of the supplies of milk surplus to the fluid needs of the market while the proceeding is under consideration.

EFFECTIVE DATE: June 3, 1986.

FOR FURTHER INFORMATION CONTACT: Constance M. Brenner, Marketing Specialist, Dairy Division, Agricultural Marketing Service, U.S. Department of Agriculture, Washington, DC 20250, (202) 447–7311.

SUPPLEMENTARY INFORMATION: Prior document in this proceeding:.

Notice of Hearing: Issued February 6, 1986; published February 11, 1986 (51 FR 5070).

The Administrator of the Agricultural Marketing Service has certified that this action will not have a significant economic impact on a substantial number of small entities. This action lessens the regulatory impact of the order on certain milk handlers and tends to ensure that dairy farmers will continue to have their milk priced under the order and thereby receive the benefits that accrue from such pricing.

This order of suspension is issued pursuant to the provisions of the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601 *et seq.*), and of the order regulating the handling of milk in the Great Basin marketing area.

It is hereby found and determined that the suspension, which applied to milk marketed through the end of April, should be extended and continued until the hearing proceeding on a proposed merger of the Great Basin and Lake Mead orders has been completed and that the following provisions of the current order do not tend to effectuate the declared policy of the Act:

(1) Section 1136.13(c)(2).

(2) In § 1136.13(c)(3), the language "*Provided,* That the total quantity of milk so diverted that exceeds 25 percent of the milk physically received at all pool plants from member producers in any month of March through August, and that exceeds 20 percent of such receipts in any month of September through February, shall not be producer milk;", and

(3) In § 1136.13(c)(4), the language "*Provided,* That the total quantity of milk so diverted that exceeds 25 percent of the milk physically received at such plant from producers who are not members of a cooperative association in any month of March through August, and that exceeds 20 percent of such receipts in any month of September through February, shall not be producer milk;".

Statement of Consideration

This action is based on the record of a public hearing held on March 18–20, 1986, at Salt Lake City, Utah, to consider a proposed merger of the Great Basin and Lake Mead orders. The Great Basin order now provides that a cooperative association may divert up to 25 percent of its producer milk physically received at pool plants in any month of March through August, and up to 20 percent of its member milk physically received at pool plants in any month of September through February. Similarly, the operator of a pool plant may divert up to 25 percent of its receipts of producer milk (for which the operator of such plant is the handler during the month) during the months of March through August, and 20 percent during the months of September through February. The order also requires that at least 6 days' production of each producer whose milk is diverted to nonpool plants be received at pool plants in order for the diverted milk to be priced and pooled under the order. The limit on the percentage of allowable diversions has been suspended since January 1985, and the 6-day "touch-base" requirement has been suspended since July 1985.

Continuation of the suspension was requested by Western General Dairies, Inc., at the March 18–20 hearing. Western General operates pool distributing plants and manufacturing plants in the Great Basin marketing area. The cooperative also supplies most of the market's fluid milk needs and handles most of the market's reserve milk supplies.

At the March hearing, witnesses for Western General testified that the order's present diversion limits and "touch-base" requirements are too restrictive to allow the cooperative to maintain the pool status of its members without the use of unnecessary and inefficient hauling practices. In order to operate within the order's diversion limits, some of the milk of the cooperative's member producers who regularly have supplied the fluid market would have to be moved, uneconomically, first to pool plants and then to nonpool manufacturing plants in order to achieve pool status for such milk. In addition, milk would have to be

moved uneconomically from distant production areas in order to meet the 6-day delivery requirement, only to displace milk produced at locations nearer the pool plants. The close-in milk must then be moved, uneconomically, to distant nonpool plants for manufacturing.

Data introduced at the hearing show that producer milk pooled under the Great Basin order in 1985 increased by 33 percent over 1984. At the same time, Class I sales by Great Basin handlers increased by only 8 percent over the same period. As a result, the volume of producer milk used in manufactured Class I and Class III products in 1985 was 61 percent greater than in 1984. The percentage of producer milk used in Class I in 1985 was 48.38 percent, as compared with 59.34 percent in 1984. Testimony received at the hearing indicated that there are many manufacturing grade dairy farmers in the area who are likely to convert their operations to Grade A status in the near future, and that many of the present Grade A producers are likely to increase production. These factors are expected to result in increasing volumes of milk production eligible for pooling under the Great Basin order in spite of the effects of the whole-herd buyout program. Given these conditions, it is very likely that some producer milk will fail to qualify for pooling or that handlers will be forced to resort to unnecessary and uneconomic hauling practices in order to maintain the producer status of their milk supply if only 20 percent of a handler's milk supply is allowed to be delivered directly to nonpool manufacturing plants.

Two pooled proprietary handlers with nonmember milk supplies testified that the current order provisions would cause them to undertake unnecessary and uneconomic hauling and handling of their producer milk supplies in order to maintain pool status for their producers. The handlers also stated that the order's present restrictive diversion limits and producer delivery requirements would make it impossible for them to maintain a large enough milk supply to be able to bid for and acquire new accounts, and thereby increase their business.

Although the diversion limits contained in Western General's proposed merged order would not be any more generous than those contained in the current Great Basin order, Western General's proposal does include in the pool plant definition a cooperative-owned manufacturing plant located in the marketing area. Adoption of this provision would allow all of Western General's milk supplies delivered to its own manufacturing plant to be considered deliveries to pool plants, and therefore not be counted as diversions. Because most of Western General's member milk that is surplus to the fluid needs of the market is delivered to Western General's manufacturing facilities, adoption of this proposed provision would allow the cooperative to maintain pool status for the milk of all of its member producers. Western General's proposed order would reduce the number of days of a producer's production that would be required to be received at pool plants from 6 to 1. Proposals supported at the hearing by the proprietary handlers would relax the present limits on the amount of a handler's milk that may be diverted to nonpool plants.

An extension of the current suspension is warranted on the basis of the foregoing information. The extension will enable Western General and other handlers to handle their reserve milk, supplies efficiently and assure that the milk of dairy farmers who supply the fluid needs of the market will continue to be pooled until such time as the hearing proceeding is completed.

It is hereby found and determined that thirty days' notice of the effective date hereof is impractical, unnecessary and contrary to the public interest in that:

(a) This suspension is necessary to reflect current marketing conditions and to assure the orderly marketing of milk in the marketing area;

(b) This suspension does not require of persons affected substantial or extensive preparation prior to the effective date; and

(c) The marketing problems that provide the basis for this action were fully explored at a public hearing held on March 18–20, 1986, where all interested parties had an opportunity to testify concerning the proposals.

Therefore, good cause exists for making this order effective upon publication in the **Federal Register.**

List of Subjects in 7 CFR Part 1136

Milk marketing orders, Milk, Dairy products.

It is therefore ordered, that the following language in § 1136.13(c) of the Great Basin milk order is hereby suspended for the month of May 1986 and continuing until the rulemkaing proceeding relating to the merger of the Great Basin and Lake Mead Federal milk orders has been completed:

PART 1136—MILK IN THE GREAT BASIN MARKETING AREA

1. The authority citation for 7 CFR Part 1136 continues to read as follows:

Authority: Sec. 1–19, 48 Stat. 31, as amended, 7 U.S.C. 601–674.

§ 1136.13 (Amended)

2. Section 1136.13(c)92) is suspended.

3. Section 1136.13(c)(3), the language *"Provided,* That the total quantity of milk so diverted that exceeds 25 percent of the milk physically received at all pool plants from member producers in any month of March through August, and that exceeds 20 percent of such receipts in any month of September through February, shall not be producer milk;" is suspended, and

4. In § 1136.13(c)(4), the language *"Provided,* That the total quantity of milk so diverted that exceeds 25 percent of the milk physically received at such plant from producers who are not members of a cooperative association in any month of March through August, and that exceeds 20 percent of such receipts in any month of September through February, shall not be producer milk;" is suspended.

Effective date: Upon publication in the **Federal Register.**

Signed at Washington, D.C. on May 28, 1986.

Karen K. Darling,

Deputy Assistant Secretary, Marketing & Inspection Services.

[FR Doc. 86-12369 Filed 6-2-86; 8:45 am]

BILLING CODE 3410-02-M

Rural Electrification Administration

7 CFR Part 1772

[REA Bulletin 345–90]

REA Specification for Totally Filled Fiber Optic Cable, PE–90

AGENCY: Rural Electrification Administration, Department of Agriculture.

ACTION: Final rule.

SUMMARY: The Rural Electrification Administration (REA) hereby amends 7 CFR 1772.97, Incorporation by Reference of Telephone Standards and Specifications, by issuing a new Bulletin 345–90, REA Specification for Totally Filled Fiber Optic Cable, PE–90. This action permits REA borrowers to routinely employ fiber optic cable, one of the most recent advances in communications technology, as an alternative to conventional cables utilizing copper conductors. With this alternative available, REA borrowers may utilize the latest technology in bringing the best, most cost-effective telecommunications to rural America. All manufacturers of

telecommuincations cables as well as all REA borrowers may be impacted to some degree.

EFFECTIVE DATE: The incorporation by reference of the publication listed in this regulation is approved by the Director of the Federal Register as of May 28, 1986.

FOR FURTHER INFORMATION CONTACT: M. Wilson Magruder, Director, Telecommunications Engineering and Standards Division, Rural Electrification Administration, Room 2835, South Building, U.S. Department of Agriculture, Washington, DC 20250, telephone (202) 382-8663. The Impact Analysis describing the options considered in developing this rule and the impact of implementing each option is available on request from the above office.

SUPPLEMENTARY INFORMATION: Pursuant to the Rural Electrification Act, as amended (7 U.S.C. 901 et seq.), REA hereby amends 7 CFR 1772.97, Incorporation by Reference of Telephone Standards and Specifications, by incorporating by reference a new Bulletin 345-90, REA Specification for Totally Filled Fiber Optic Cable, PE-90. Copies of the bulletin are available upon request from the address stated above. It is also available for inspection at the Office of the Federal Register, Room 8401, 1101 L Street, NW., Washington, DC 20408. These materials are incorporated as they existed on the date of the approval and a notice of any change in these materials will be published in the **Federal Register**. The action will not (1) have an annual effect on the economy of $100 million or more; (2) result in a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; (3) result in significant adverse effects on competition, employment, investment or productivity, innovations, or on the ability of the United States-based enterprises to compete with foreign-based enterprises in domestic or export markets and therefore has been determined to be "not major". This action does not fall within the scope of the Regulatory Flexibility Act. REA has concluded that promulgation of this rule would not represent a major Federal action significantly affecting the quality of the human environment under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.* (1976)) and, therefore, does not require an environmental impact statement or an environmental assessment. This program is listed in the Catalog of Federal Domestic Assistance under No. 10.851, Rural Telephone Loans and Loan Guarantees and 10.852, Rural Telephone Bank Loans. For the reasons set forth in the Final rule related Notice to 7 CFR Part 3015, Subpart V (48 FR 54317, December 1, 1983), this program is excluded form the scope of Executive Order 12372 which requires intergovernmental consultation with State and local officials.

Copies of the document are available upon request from the address indicated above.

Background

REA has issued a series of publications entitled "bulletins" which serve to implement the policy, procedures and requirements for administering its loans and loan guarantee programs and the security instruments which provide for and secure REA financing. In the bulletin series REA issues standards and specifications for the construction of telephone facilities financed with REA loan funds. REA presently has no specification for fiber optic cables, so their use on the systems of REA borrowers is severely restricted. This new specification PE-90, establishes the minimum requirements for fiber optic cables that are used for direct burial, underground and aerial applications on REA-financed systems. The conductors are solid glass waveguides consisting of a cylindrical core surrounded by protective coverings. The cables are used as the transport media for transmission of voice, data, pictures and signals between telephone subscribers. Fiber optic cables have lower attenuation loss and increased bandwidth when compared to copper pairs in conventional telephone cable. This allows for high capacity transmission systems at lower cost to meet initial requirements and at the same time provide for future growth in an economical manner. The specification also requires properties which will assure that the fiber optic cables are capable of withstanding the rigors of conventional installation methods and providing reliable long-term service. Neither manufacturing techniques nor purchase price will be adversely affected by this action.

A Notice of Proposed Rulemaking was published in the **Federal Register** on October 7, 1985, Volume 50, No. 194, page 40865. The following four comments were received concerning the proposal:

1. The core ellipticity should be increased from 2 percent to 6 percent which would still be within the core diameter specification of 50±3 micrometers.

2. The numerical aperture (NA) of .20±.02 should be expanded to .24±.02 or to .22±.02 because computerized lathes allow improved bandwidths with a larger NA.

3. The compound flow test parameters should be rewritten to remove any ambiguity.

4. The limit of 0.1 dB/km following temperature and humidity exposure should be expanded to allow a change of 0.2 dB/km because of measurement uncertainty.

REA's response to these comments is summarized as follows:

1. From a strictly dimensional consideration of individual fibers a 6 percent ellipticity requirement would be reasonable but REA must look beyond the single fiber to consider the ramifications of joining two dimensionally unmatched fibers at a splice point. To effect maximum light transfer through a splice in either direction the cores should be perfectly matched. Since a zero variance would be near impossible with present fiber manufacturing technology, REA has chosen to allow the core area mismatched by ellipticity (2 percent) to be no greater than the possible core area mismatch allowed by the diameter extremes (±3 microns).

2. The goal of REA in writing PE-90 with the NA requirement of .20±.02 is to standardize realistic properties of optical fibers that are available and will yield a quality product sufficient to meet the transmission needs of rural telecommunication companies. The .20±.02 NA meets this goal of standardization of optical properties, is available from most optical fibers manufacturers and yields an acceptable bandwidth. A compromise to another NA value would contribute nothing additional to the standardization goal of REA.

3. The compound flow test of Paragraph 18 is being rewritten to prevent any misinterpretation. Paragraph 18.1 is not altered but Paragraph 18.2 is revised to allow cable specimens to be prepared extraordinarily long or to be capped to simulate the vacuum and capillary effects of inservice cable. Also a dish now must be placed immediately below the vertically suspended cable specimen. A paragraph defining failure was added: "18.3 Evidence that either the filling or flooding compound flowed or dripped from any of the suspended cable specimens shall constitute failure."

4. The limit of 0.1 dB/km following temperature and humidity exposure is necessary to reveal any flaws that may

be inherent in a fiber optic cable design submitted to REA for acceptance and listing in the REA Bulletin 344–2. The uncertainty of the measurements introduced by equipment limitation and operator repeatability is outweighed by the net benefit to the manufacturer and to REA by the 0.1 dB/km requirement compared to the 0.2 dB/km request. REA elects to keep the 0.1 dB/km requirement in the specification for qualification of totally filled fiber optic cable.

List of Subjects in 7 CFR Part 1772

Loan programs-communications, Telecommunications, Telephone, Incorporation by reference.

PART 1772—[AMENDED]

In view of the above, REA hereby amends 7 CFR Part 1772 by issuing a new Bulletin 345–90.

1. The authority cited for 7 CFR Part 1772 is revised to read as follows:

Authority: 7 U.S.C. 901 et seq., 7 U.S.C. 1921 et seq.

2. The table in § 1772.97 is amended by adding the entry 345–90 to read as follows:

§ 1772.97 Incorporation by reference of telephone standards and specifications.

* * * * *

345–90	PE–90	REA specification for totally filled fiber optic cable.

* * * * *

Dated: May 28, 1986.

Harold V. Hunter,

Administrator.

[FR Doc. 86–12426 Filed 6–2–86; 8:45 am]

BILLING CODE 3410–15–M

DEPARTMENT OF JUSTICE

Immigration and Naturalization Service

8 CFR Parts 100 and 103

Organization Changes; Powers and Duties of Service Officers and Availability of Service Records

AGENCY: Immigration and Naturalization Service, Justice.

ACTION: Final rule.

SUMMARY: This rule amends the Immigration and Naturalization Service regulations to reflect a recent organization change approved by the Attorney General. The change combines the Offices of Field Inspections and Audit with Evaluation to form the new Office of Program Inspection. This change is made to improve the management, direction and control of Service programs and enhance overall efficiency of the Service.

EFFECTIVE DATE: February 16, 1986.

FOR FURTHER INFORMATION CONTACT:

For General Information: Loretta J. Shogren, Director, Policy Directives and Instructions, Immigration and Naturalization Service, 425 I Street, NW., Washington, DC 20536, Telephone: (202) 633–3048

For Specific Information: Robert A. Andersen, Director, Office of Program Inspection, Immigration and Naturalization Service, 425 I Street, NW., Washington, DC 20536, Telephone: (202) 633–4097.

SUPPLEMENTARY INFORMATION: On October 4, 1985, the proposed reorganization of the Office of the Commissioner of the Immigration and Naturalization Service was approved by the Attorney General. Notification of the Service's reorganization was then sent to the Office of Management and Budget, and finally, to the Congress for their approval. This reorganization allows the Office of Evaluation to combine functions with the Office of Field Inspections and Audit to form a new unit titled the Office of Program Inspection. The combination of these offices will aid the Service in achieving the goal of improving performance and effectiveness of INS programs.

Compliance with 5 U.S.C. 553 as to notice of proposed rulemaking and delayed effective date is unnecessary as this rule relates solely to agency organization and management.

In accordance with 5 U.S.C. 605(b), the Commissioner of Immigration and Naturalization certifies that this rule does not have a significant impact on a substantial number of small entities. This rule is not a rule as defined in section 1(a) of E.O. 12291 as it relates to agency organization and management.

List of Subjects in 8 CFR Parts 100 and 103

Administrative practice and procedure, Authority delegation, Organization and functions.

Accordingly, Chapter I of Title 8 of the Code of Federal Regulations is amended as follows:

PART 100—STATEMENT OF ORGANIZATION

1. The authority citation for Part 100 continues to read as follows:

Authority: Sec. 103 of the Immigration and Nationality Act, as amended; (8 U.S.C. 1103).

2. In § 100.2, paragraphs (a)(4) and (b)(2) are revised to read as follows:

§100.2 Organization and functions.

(a) * * *

(4) *Office of Program Inspection.* Headed by the Director for Program Inspection who is subject to the general supervision and direction of the Comissioner and who supervises, directs, and coordinates the Field Inspections and Program Audit and the Evaluation and Productivity Improvement Programs.

(b) * * *

(2) *Office of Management.* Headed by the associate Commissioner for Management who is responsible for planning, developing, directing, coordinating, and reporting on Servce management programs and activities and participating in formulating Service management policies. The Associate Commissioner for Management directly supervises:

(i) Office of the Comptroller,

(ii) Personnel and Training Division,

(iii) Administration Division, and

(iv) Office of Equal Employment Opportunity.

* * * * *

PART 103—POWERS AND DUTIES OF SERVICE OFFICER; AVAILABILITY OF SERVICE RECORDS

3. The authority citation for Part 103 continues to read as follows:

Authority: Sec. 103 of the Immigration and Nationality Act, as amended; (8 U.S.C. 1103).

4. In § 103.1, paragraphs (d) and (j) are revised to read as follows:

§103.1 Delegations of Authority.

* * * * *

(d) *Associate Commissioner for Management.* Under the direction of the Deputy Commissioner, the Associate Commissioner for Management is delegated authority and responsibility for program planning, development, coordination, counseling, and staff direction of the Comptroller, Personnel and Training, Administration, Equal Employment Opportunity programs and general direction to and supervision of:

(1) Comptroller,

(2) Assistant Commissioner for Personnel and Training,

(3) Assistant Commissioner for Administration, and

(4) Director for Equal Employment Opportunity.

* * * * *

(j) *Director for Program Inspection.* Under the direction of the Commissioner, the Director for Program Inspection is delegated the responsibility for program planning, development, coordination, and execution of field inspections and program audits; program evaluation and productivity improvements; the decision memo process; and executive video reports. The Director reports to the Commissioner, in a timely manner, the results and recomendation of all completed studies and reports.

* * * * *

Dated: May 29, 1986.

Alan C. Nelson,

Commissioner, Immigration and Naturalization Service.

[FR Doc. 12342-86 Filed 6-2-86; 8:45 am]

BILLING CODE 4410-10-M

FEDERAL RESERVE SYSTEM

12 CFR Part 265

[Docket No. R-0574]

Rules for Delegations of Authority; Change in Bank Control Act

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Amendment of final rule.

SUMMARY: On October 21, 1982, the Board published in the **Federal Register** (47 FR 46839 (1982)) an amendment to a final rule which expanded the delegated authority of the General Counsel to include authority to revoke acceptance of and return a notice filed pursuant to the Change in Bank Control Act, or to extend the time during which action must be taken on such a notice where the General Counsel has determined, with the concurrence of the Board's Director of Banking Supervision and Regulation, that the notice is materially incomplete or contains material information that is substantially inaccurate. The effective date was October 15, 1982. This amendment was designated as paragraph (b)(10). Paragraph (b)(10) was then inadvertantly removed from the Code of Federal Regulations when the Board published on February 14, 1984, a new paragraph (b)(10), relating to public meetings concerning any application or notice filed with the Board (49 FR 5605 (1984)). This, the current paragraph (b)(10), should have been published as a new paragraph (b)(11). The Board is now publishing an amendment to reinsert the original paragraph (b)(10), and to redesignate the current paragraph (b)(10) as paragraph (b)(11).

EFFECTIVE DATE: June 3, 1986.

FOR FURTHER INFORMATION CONTACT: J. Virgil Mattingly, Deputy General Counsel (202/452-3430), or Scott G. Alvarez, Senior Attorney (202/452-3583), Legal Division, or for users of the Telecommunications Device for the Deaf (TDD), Earnestine Hill or Dorothea Thompson (202/452-3544), Board of Governors of the Federal Reserve System, Washington, DC 20551.

List of Subjects in 12 CFR Part 265

Authority, delegations (Government agencies), Banks, banking, Federal Reserve System.

PART 265—RULES REGARDING DELEGATION OF AUTHORITY

For the reasons set forth in the preamble, Title 12, Part 265 of the Code of Federal Regulations, is amended as follows:

1. The authority citation for 12 CFR Part 265 continues to read as follows:

Authority: Sec. 11(k), 38 Stat. 261 and 80 Stat. 1314; 12 U.S.C. 248(k).

2. Section 265.2 is amended by redesignating the current paragraph (b)(10) as paragraph (b)(11) and by adding a new paragraph (b)(10) to read as follows:

§ 265.2 Specific functions delegated to Board employees and to Federal Reserve Banks.

* * * * *

(b) * * *

(10) To revoke acceptance of and return as incomplete a notice filed pursuant to the Change in Bank Control Act (12 U.S.C. 1817(j)) or to extend the time during which action must be taken on a notice where the General Counsel determines, with the concurrence of the Board's Director of Banking Supervision and Regulation, that the notice is materially incomplete under the Change in Bank Control Act or the Board's regulation promulgated thereunder or contains material information that is substantially inaccurate.

* * * * *

By order of the Board of Governors of the Federal Reserve System, May 29, 1986.

William W. Wiles,

Secretary of the Board.

[FR Doc. 86-12457 Filed 6-2-86; 8:45 am]

BILLING CODE 6210-01-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 86-AWP-10]

Amendment of Tustin MCAS H, California, And Santa Ana Orange County, CA, Control Zones

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends the description of the Tustin MCAS H, California, and Santa Ana Orange, County, California, control zones. These amendments are editorial only and will provide a complete and accurate description of the control zones.

EFFECTIVE DATE: 0901 UTC; August 28, 1986.

FOR FURTHER INFORMATION CONTACT: Frank T. Torikai, Airspace Specialist, Airspace Branch, AWP-520, Air Traffic Division, Western-Pacific Region, Federal Aviation Administration, 15000 Aviation Boulevard, Lawndale, California 90260; telephone (213) 297-1649

The Rule

These amendments to Part 71 of the Federal Aviation Regulations are editorial in nature only and will correct the descriptions of the Tustin MCAS H, California, and Santa Ana Orange County, California, control zones. I find that notice and public procedure under 5 U.S.C. 553(b) are unnecessary because these actions are minor amendment is which the public would not be particularly interested.

Section 71.171 of Part 71 of the Federal Aviation Regulations was republished in Handbook 7400.6B dated January 2, 1986.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only effect air traffic procedures and air navigation, it is certified that this rule will not have a significant economic impact on a substantial number of small entities

under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Aviation safety/control zones.

Adoption of the Amendment

PART 71—[AMENDED]

Accordingly, pursuant to the authority delegated to me, Part 71 of the Federal Aviation Regulations (14 CFR Part 71) is amended as follows:

1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 1348(a), 1354(a), 1510; Executive Order 10854; 49 U.S.C. 106(g) (Revised Pub. L. 97-449, January 12, 1983); 14 CFR 11.69.

3. Section 71.171 is amended as follows:

Santa Ana Orange County Airport, CA—[AMENDED].

Remove "MCAS Santa Ana (lat. 33 °42 '22 " N., 117 °49 '35 " W.)" and substitute "Tustin MCAS (lat. 33 °42 '22 " N., long. 117 °49 '35 " W.)."

Tustin MCAS H, CA—[AMENDED.

Add the following sentence to the end of the present control zone description: "However, at other times, the control zone is under control jurisdiction of Santa Ana Orange County."

Issued in Los Angeles, California, on May 21, 1986.

Wayne C. Necomb,

Manager, Air Traffic Division.

[FR Doc. 86-12321 Filed 6-2-86; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 510

[Docket No. 79P-0197]

New Animal Drug Requirements for Medicated Free-Choice Feeds

AGENCY: Food and Drug Administration.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the new animal drug regulations covering requirements for approval of applications for medicated free-choice feed products. The regulations will allow for an optional method of submitting data to FDA within the framework of existing requirements. This action is being taken based on a citizen petition filed jointly by the American Feed Manufacturers Association (AFMA) and the Animal Health Institute (AHI) and the agency's evaluation of current regulatory requirements. In a document published elsewhere in this issue of the **Federal Register**, the agency is announcing the availability of two draft guidelines, one covering the evaluation of effectiveness of new animal drugs for use in free-choice feeds and the other covering current good manufacturing practice concerning such products. These guidelines are intended to replace the existing "Cattle Medicated Block Guidelines."

EFFECTIVE DATE: July 3, 1986.

FOR FURTHER INFORMATION CONTACT: Richard P. Lehmann, Center for Veterinary Medicine (HFV-120), Food and Drug Administration, 5600 Fishers Lane, Rockville MD 20857, 301-443-3134.

SUPPLEMENTARY INFORMATION:

Background

In the **Federal Register** of November 19, 1984 (49 FR 45593), FDA published a proposal to amend § 510.455 *New animal drug requirements for medicated blocks* (21 CFR 510.455) of the new animal drug regulations.

The proposal was based on FDA's evaluation of current regulatory requirements in light of a citizen petition that was filed jointly by AFMA and AHI on June 6, 1979. They requested in the petition that FDA regulate medicated blocks and similar articles as medicated feeds rather than as new animal drugs. They asked FDA to recognize that medicated blocks, liquid feed supplements, and similar "free-choice" articles are, under the provisions of the Federal Food, Drug, and Cosmetic Act (the act), "animal feeds bearing or containing new animal drugs" rather than "new animal drugs" and thus should be regulated as medicated feeds.

The petition recognized that use of medicated free-choice feeds posed questions not posed by other medicated feeds with regard to composition of the feed, stability, and consumption of the drug product. The petition contended that the information necessary to respond to these questions could be submitted in medicated feed applications and that drug sponsors and feed manufacturers are willing to provide those data. The petition stated that the drug manufacturer and the medicated feed applicant would each supply part of the data demonstrating that a safe and effective dose of the drug would be provided by a particular free-choice product. The petition suggested submission of data in master files to permit each manufacturer to retain the confidentiality of its data.

FDA evaluated the petition and concluded that the revisions suggested would simplify the approval process in a manner consistent with the act and regulations. FDA proposed to grant in substance the relief sought.

Comments

The proposal provided for a comment period of 60 days. The agency received four comments on the proposal. These comments were from an animal drug manufacturer, a manufacturer of feed blocks, an agricultural consultant, and one joint comment from two trade associations.

The agency has carefully evaluated the comments received and, in response to these comments, has modified certain aspects of the proposed regulations.

1. Comments contended that the definition of medicated blocks in proposed § 510.455(a) should indicate that medicated blocks can be produced from agglomerated feed rendered into a solid mass. This provides for production of blocks by means other than compression as stated in the proposal.

The agency concurs with the addition of "or rendered" in the definition of medicated blocks because blocks may be produced by procedures other than compression.

2. Comments contended that the term "mineral mixes" is inadequate and suggested use of the term "loose self-limiting mixtures." The comments suggested this change because free-choice supplements may contain considerably less than 50 percent mineral content by weight.

The agency does not concur with the substitution of terms because the term "mineral mixes" is used in the feed industry and has a recognized meaning as a free-choice source of minerals. Such products may also contain vitamins but do not contain significant amounts of energy, protein, or fat. The term "mineral mixes" is preferred because the suggested term "loose self-limiting mixtures" is new and has no generally recognized definition or history of use.

3. One comment suggested that terms be defined in the final regulation.

The agency does not concur because the terminology used is familiar to users of free-choice products and the regulated industry and adequately conveys the intent of the agency. The "Guidelines for Evaluation of Effectiveness of New Animal Drugs for Use in Free-Choice Products," which is the subject of a notice published elsewhere in this issue of the **Federal Register**, as discussed above, has "Definition," "Research Model," and "Administrative Procedures" sections,

which expand on the practical interpretation of the regulation.

4. One comment stated that the proposed regulation failed to stress the need for validation of effectiveness by formulation and by the specific final feed manufacturing form.

The agency does not believe it is necessary for this regulation to have the emphasis suggested by the comment. Section 512 of the act (21 U.S.C. 360b) and 21 CFR Part 514 require the submission of data demonstrating effectiveness for products containing new animal drugs. The submission of data in master files does not reduce the amount of data needed to establish safety and effectiveness for products.

5. Comments stated that the proposed regulation made several references to "specific free-choice feeds" and similar wording. The comments stated that the references appeared to rule out any flexibility by the manufacturer of free-choice medicated feeds.

The agency believes that formula flexibility is necessary and that a formula type or formula matrix should be established in the master file. Firms submitting medicated feed applications would then certify that each free-choice feed was manufactured in accordance with the formula matrix established in the master file for such products. This would provide needed flexibility yet assure that such medicated feeds are within the consumption and stability patterns demonstrated.

6. The comments included proposed wording for § 510.455(e) to introduce a new term "formula matrix" and to use this term to assure flexibility for products to be approved under a medicated feed application.

The agency agrees that formula flexibility is necessary for free-choice feeds. The final regulation does not prohibit the testing of a variable product. If data submitted in the appropriate new animal drug application or master file provide for ranges of ingredients, the medicated feed applications may request approval of products formulated within the ranges of ingredients approved. Existing free-choice feed approvals are permitted to vary ingredients based on a batch formula, which may have ranges for each ingredient. The agency believes that there is no need to introduce new terms because the relief sought is already provided for.

7. Comments stated that data necessary to establish the effectiveness and safety of medicated free-choice feeds should be described by the agency. The comments requested the agency to recognize that, once the effectiveness of a new animal drug in one form and type of free-choice feed has been established for an animal class, the animal drug would then be deemed effective when provided to that animal class in another feed form if the drug is stable in the feed and consumed at efficacious levels.

The agency concurs and the guidelines referred to above address such data collection processes for medicated free-choice feeds.

8. Comments suggested that the agency allow free-choice feed manufacturers to interchange some feed ingredients without submission of a supplemental application containing additional consumption and stability data. This would permit the manufacturer to adjust the formulation according to ingredient cost. The formulation adjustments would be within ranges that would maintain product nutrient levels and would be limited to changes that would not alter the palatability of the free-choice feeds or drug stability.

The agency agrees that there is a need for flexibility in the manufacture of free-choice feeds to reflect market changes in ingredient availability and cost. The agency will allow flexibility in the level of ingredients as provided for in approved batch formulations. A medicated free-choice product may also be manufactured using interchangeable nutrients as provided for in approved batch formulations. The agency also agrees that a free-choice product may interchange nutrients where such interchange has been demonstrated to be acceptable and still be considered a "specific free-choice feed."

Conclusion

The agency has reviewed and evaluated the comments received and has revised proposed § 510.455(a) to include medicated blocks that are produced by being rendered into a solid mass. The agency has also considered the matter of free-choice products regulated as dosage form products under 21 CFR Part 520 and has concluded that products currently covered by regulations in Part 520 will for the present time remain in that part.

This final rule has further been revised to be consistent and in accord with revisions to the medicated feed regulations published in the **Federal Register** of March 3, 1986 (51 FR 7382). The nomenclature included in revised § 558.3 *Definitions and general considerations applicable to this part* has been adopted. Because medicated free-choice feeds pose questions not posed by other medicated feeds, the exemption from the requirement of an approved medicated feed application provided in § 558.4 does not apply to any medicated free-choice feed.

Environmental Impact

The November 19, 1984, proposal discussed the environmental impact of the proposal and concluded that neither an environmental assessment nor an environmental impact statement was required. The proposal also considered the proposed action in accordance with Executive Order 12291 and determined that the proposal rule was not a major rule as defined by that Order.

Regulatory Flexibility Act

The proposal also considered the action in accordance with the requirements of the Regulatory Flexibility Act (Pub. L. 96–354) and concluded that the effect of the proposal would be to reduce regulatory burdens currently affecting both large and small business. FDA certified in accordance with section 605(b) of the Regulatory Flexibility Act that no significant impact on a substantial number of small entities will derive from this action.

Paperwork Reduction Act of 1980

Section 510.455(e) of this final rule contains collection of information requirements that was submitted for review and approval to the Director of the Office of Management and Budget (OMB), as required by section 3507 of the Paperwork Reduction Act of 1980. The requirements were approved and assigned OMB control number 0910–0205.

List of Subjects in 21 CFR Part 510

Administrative practice and procedure, Animal drugs, Labeling, Reporting and recordkeeping requirements.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, Part 510 is amended as follows:

PART 510—NEW ANIMAL DRUGS

1. The authority citation for 21 CFR Part 510 continues to read as follows:

Authority: Secs. 512, 701(a), 52 Stat. 1055, 82 Stat. 343–351 (21 U.S.C. 360b, 371(a)); 21 CFR 5.10 and 5.83.

2. By revising § 510.455 to read as follows:

§ 510.455 New animal drug requirements regarding free-choice administration in feeds.

(a) For the purpose of this section, free-choice administration of animal drugs in feeds involves feeds that are

placed in feeding or grazing areas and are not intended to be consumed fully at a single feeding or to constitute the entire diet of the animal. Such methods of administering drugs include, but are not limited to, medicated blocks (agglomerated feed compressed or rendered into a solid mass and cohesive enough to hold its form), mineral mixes, and liquid feed tank supplements ("lick tank" supplements) containing one or more animal drugs. The manufacture of medicated free-choice feeds is subject to the current good manufacturing practice regulations for medicated feeds.

(b) The Food and Drug Administration has concluded that there are questions about the safety and effectiveness of drugs when administered in free-choice feeds. Therefore, such methods of administration cause the drugs so administered to be new animal drugs, for which approved new animal drug applications (NADA's) are required. (See § 510.3(i)). In addition, the exemption from the requirement of an approved medicated feed application provided in § 558.4 of this chapter does not apply to any free-choice medicated feed.

(c) An NADA or supplemental NADA for products for free-choice feeding submitted for approval under section 512(b) of the act shall provide for:

(1) The manufacture of a finished product for the free-choice administration of a new animal drug. Such an approval will not provide a basis upon which an application can be approved under section 512(m) of the act; or

(2) The manufacture of a Type A medicated article for use in the subsequent manufacture of a free-choice medicated feed. The approved NADA will provide a basis upon which an application can be approved under section 512(m) of the act. Data for a specific free-choice product may, if desired, be generated and submitted to the Food and Drug Administration by the manufacturer of the free-choice feed in the form of a master file which can be referenced in the NADA or supplemental NADA submitted by the new animal drug sponsor.

(d) Approval of the NADA or supplemental NADA submitted under paragraph (c) of this section will be reflected in a regulation in Part 558 of this chapter published under section 512(i) of the act. The regulation will either state the formulation of the approved free-choice product or specify the specific free-choice administration products in which the drug is approved for use. If the approval is for a Type A medicated article, the regulation in Part 558 of this chapter will indicate that each use of the Type A medicated article in a free-choice product must be the subject of an approved supplemental NADA.

(e) An application submitted under section 512(m) of the act to provide for manufacture of a specific free-choice feed from an approved Type A medicated article will be approved if, in addition to the information required by the medicated feed application, it includes a reference to the exact formula of the product to be manufactured as follows:

(1) The formula is the same as the one published in the new animal drug regulations; or

(2) The data in a master file have been referenced in an NADA or supplemental NADA; and

(3) Use of the Type A medicated article in the specific formulation has been approved on the basis that:

(i) The formula is the same as the one for which acceptable data have been submitted in a master file by the medicated feed applicant; or

(ii) The medicated feed applicant has written authority to reference a master file that has acceptable data for the formula in question.

(Collection of information requirements were approved by the Office of Management and Budget (OMB) and assigned OMB control number 0910-0205.)

Dated: May 13, 1986.

Joseph P. Hile,

Associate Commissioner for Regulatory Affairs.

[FR Doc. 86-12346 Filed 6-2-86; 8:45 am]

BILLING CODE 4160-01-M

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21 CFR Parts 510 and 558

New Animal Drugs for Use in Animal Feeds; Tylosin and Sulfamethazine

AGENCY: Food and Drug Administration.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the new animal drug regulations to reflect approval of a new animal drug application (NADA) filed for Agri-Basics, ConAgra-Westfeeds, providing for the making of Type A medicated articles containing 5, 10, 20, or 40 grams per pound each of tylosin and sulfamethazine. The Type A medicated articles are for making Type C medicated feeds for use in swine. Additionally, the list of sponsors of approved applications in the regulations is amended by adding the applicant.

EFFECTIVE DATE: June 3, 1986.

FOR FURTHER INFORMATION CONTACT: Benjamin A. Puyot, Center for Veterinary Medicine (HFV-135), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-443-1414.

SUPPLEMENTARY INFORMATION: Agri-Basics, ConAgra-Westfeeds, 1420 Minnesota Ave., Billings, MT 59101, is the sponsor of NADA 140-530 submitted on its behalf by Elanco Products Co. The NADA provides for the manufacture of Type A medicated articles containing 5, 10, 20, or 40 grams per pound each of tylosin (as tylosin phosphate) and sulfamethazine. The Type A medicated articles are to make Type C medicated feeds for use in swine for maintaining weight gains and feed efficiency in the presence of atrophic rhinitis, lowering the incidence and severity of *Bordetella bronchiseptica* rhinitis, prevention of swine dysentery (vibrionic), and control of swine pneumonias caused by bacterial pathogens (*Pasteurella multocida* and/or *Corynebacterium pyogenes*). The NADA is approved and the regulations are amended to reflect the approval. Additionally, the regulations are amended to add Agri-Basics, ConAgra-Westfeeds to the list of sponsors of approved applications. The basis for approval is discussed in the freedom of information summary.

In accordance with the freedom of information provisions of Part 20 (21 CFR Part 20) and § 514.11(e)(2)(ii) (21 CFR 514.11(e)(2)(ii)), a summary of safety and effectiveness data and information submitted to support approval of this application may be seen in the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857, from 9 a.m. to 4 p.m., Monday through Friday.

The agency has determined under 21 CFR 25.24(d)(1)(i) (April 26, 1985; 50 FR 16636) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

List of Subjects

21 CFR Part 510

Admninistrative practice and procedure, Animal drugs, Labeling, Reporting and recordkeeping requirements.

21 CFR Part 558

Animal drugs, Animal feeds.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Veterinary Medicine, Parts 510 and 558 are amended as follows:

PART 510—NEW ANIMAL DRUGS

1. The authority citation for 21 CFR Part 510 continues to read as follows:

Authority: Secs. 512, 701(a), 52 Stat. 1055, 82 Stat. 343–351 (21 U.S.C. 360b, 371(a)); 21 CFR 5.10 and 5.83.

2. Section 510.600 is amended in paragraph (c)(1) by adding a new sponsor entry alphabetically and in paragraph (c)(2) by adding a new entry numerically to read as follows:

§ 510.600 Names, address, and drug labeler codes of sponsors of approved applications.

* * * * *

(c) * * *

(1) * * *

Firm name and address	Drug labeler code
• • • • •	
Agri-Basics, ConAgra-Westfeeds, 1420 Minnesota Ave., Billings, MT 59101	023368
• • • • •	

(2) * * *

Drug labeler code	Firm name and address
023368	Agri-Basics, ConAgra-Westfeeds, 1420 Minnesota Ave, Billings, MT 59101.
• • • • •	

PART 558—NEW ANIMAL DRUGS FOR USE IN ANIMAL FEEDS

3. The authority citation for 21 CFR Part 558 continues to read as follows:

Authority: Sec. 512, 82 Stat. 343–351 (21 U.S.C. 360b); 21 CFR 5.10 and 5.83.

§ 558.630 [Amended]

4. Section 558.630 *Tylosin and sulfamethazine* is amended in paragraph (b)(10) by inserting numerically the number "023368."

Dated: May 27, 1986.

Gerald B. Guest,

Acting Director, Center for Veterinary Medicine.

[FR Doc. 86-12344 Filed 6-2-86; 8:45 am]

BILLING CODE 4160-01-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Secretary

24 CFR Part 13

[Docket No. R-86-1289; FR-2226]

Procedures for Use of Penalty Mail in the Location and Recovery of Missing Children

AGENCY: Office of the Secretary, HUD.

ACTION: Final rule.

SUMMARY: This rule establishes the procedures under which the Department may use penalty mail to aid in the location and recovery of missing children.

EFFECTIVE DATE: July 21, 1986.

FOR FURTHER INFORMATION CONTACT: Sandra L. Timbrook, Chief, Mail and Transportation Branch, Office of Administrative and Management Services, Room 5176, Department of Housing and Urban Development, 451 Seventh Street, NW., Washington, DC 20410. Telephone: (202) 755-5703. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Section 1(a) of S. 1195, Pub. L. 99-87, 99 Stat. 290, August 9, 1985, adds to Chapter 32 of title 39, United States Code, new provisions to authorize each executive department and independent establishment of the Government of the United States, to use official mail to aid in the location and recovery of missing children. The passage of S. 1195 reflects an increasing public concern with the problem of missing and exploited children.

Newly added 39 U.S.C. 3220(a)(1) directs the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the Department of Justice, after consultation with appropriate public and private agencies, to prescribe general guidelines under which penalty mail may be used to assist in the location and recovery of missing children. These guidelines were published on November 8, 1985 (50 FR 46622). In addition, 39 U.S.C. 3220(a)(2) requires each executive department and independent establishment of the Government of the United States to promulgate regulations under which penalty mail sent by such departments and establishments may be used in conformance with the OJJDP guidelines.

This rule is being promulgated in compliance with 39 U.S.C. 3220(a)(2) and in conformance with the OJJDP guidelines. The rule sets forth information on U.S. Postal Service restrictions on the placement of information on envelopes, "shelf-life" restrictions on the use of missing children information, and other administrative factors which are applicable.

HUD will receive camera-ready photographic and biographical information on missing children through the National Center for Missing and Exploited Children. HUD will then give priority to the use of missing children information in mail addressed to members of the public.

The Secretary has determined that notice and prior public procedure are impracticable and contrary to the public interest and that good cause exists for making this rule effective as soon after publication as possible because of the overwhelming national concern that this rule addresses. Any delay in effectiveness would clearly be counter to the national effort to locate and recover missing children.

Findings and Other Matters

Environment Impact

A Finding of No Significant Impact with respect to the environment is not necessary for this rule in accordance with HUD regulations at 24 CFR Part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969, 42 U.S.C. 4332. Under 24 CFR 50.20, this rule is categorically exempt because it pertains only to an administrative procedure concerning the dissemination of public information.

Regulatory Impact Analysis

This rule does not constitute a "major rule" as that term is defined in section 1(b) of the Executive Order on Federal Regulations issued by the President on February 17, 1981 (E.O. 12291). Analysis of the rule indicates that it does not: (1) Have an annual effect on the economy of $100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or (3) have a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to complete with foreign-based enterprises in domestic or export markets.

Regulatory Flexibility Certification

Under the provisions of 5 U.S.C. 605(b) (the Regulatory Flexibility Act), the Undersigned hereby certifies that this rule does not have a significant economic impact on a substantial number of small entities because it pertains only to an administrative

procedures concerning the dissemination of public information.

Semiannual Agenda of Regulations

This rule was not listed in the Department's Semiannual Agenda of Regulations published on April 21, 1986 (51 FR 14036) pursuant to Executive Order 12291 and the Regulatory Flexibility Act.

Accordingly, Title 24 of the Code of Federal Regulations is amended by adding a new Part 13 to read as follows:

PART 13—USE OF PENALTY MAIL IN THE LOCATION AND RECOVERY OF MISSING CHILDREN

Sec.

Authority: The Missing Children's Assistance Act of 1984, Pub. L. 98-473, October 12, 1984; S. 1195 "Official Mail Use in the Location and Recovery of Missing Children", Pub. L. 99-87, 39 U.S.C. 3220.

§ 13.1 Purpose.

To support the national effort to locate and recover missing children, the Department of Housing and Urban Development (HUD) joins other executive departments and independent establishments of the Government of the United States in using official mail to disseminate photographs and biographical information on hundreds of missing children.

§ 13.2 Procedures for obtaining and disseminating data.

(a) HUD shall insert, manually and via automated inserts, pictures and biographical data related to missing children in domestic penalty mail directed to members of the public in the United States, its territories and possessions. These include:

(1) Standard letter-size envelopes (4½" X 9½");

(2) Document-size envelopes (9½" X 12", 9½" X 11½", 10" X 13"); and

(3) Other envelopes (miscellaneous size).

(b) Missing children information shall not be placed on the "Penalty Indicia", "OCR Read Area", "Bar Code Read Area", and "Return Address" areas of letter-size envelopes.

(c) Posters containing pictures and biographical data shall be placed on bulletin boards in Headquarters and Field offices.

(d) HUD shall accept camera-ready and other photographic and biographical materials solely from the National Center for Missing and Exploited Children (National Center). Photographs that were reasonably current as of the time of the child's disappearance shall be the only acceptable form of visual media or pictorial likeness used in penalty mail or posters.

§ 13.3 Withdrawal of data.

HUD shall remove all printed penalty mail envelopes and other materials from circulation or other use within a three month period from the date the National Center receives information or notice that a child, whose picture and biographical information have been made available to HUD, has been recovered or that the parent or guardian's permission to use the child's photograph and biographical information has been withdrawn. The HUD contact person shall be notified immediately and in writing by the National Center of the need to withdraw from circulation penalty mail envelopes and other materials related to a particular child.

§ 13.4 Reports.

HUD shall compile and submit to Office of Juvenile Justice and Deliquency Prevention (OJJDP), by June 30, 1987, a consolidated report on its experience in implementing S. 1195 "Official Mail Use in the Location and Recovery of Missing Children" along with recommendations for future Departmental action.

Dated: May 26, 1986.

Samuel R. Pierce, Jr.,

Secretary.

[FR Doc. 86-12449 Filed 6-2-86; 8:45 am]

BILLING CODE 4210-01-M

DEPARTMENT OF DEFENSE

Department of the Navy

32 CFR Part 754

Navy Affirmative Salvage Claims

AGENCY: Department of the Navy, DOD.

ACTION: Removal of part from CFR.

SUMMARY: This document removes Part 754 from title 32 of the *Code of Federal Regulations*. This action is being taken because the underlying regulation, NAVSEA Instruction 4740.4, Ship salvage operations; U.S. Navy affirmative salvage claims arising from, has been cancelled.

FOR FURTHER INFORMATION CONTACT: Dale Uhler, (202) 697-7386.

PART 754—[REMOVED]

Accordingly, Part 754 is removed from title 32, CFR.

Dated: May 27, 1986.

Harold L. Stoller, Jr.,

CDR, JAGC, USN, Federal Register Liaison Officer.

[FR Doc. 86-12392 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-AE-M

DEPARTMENT OF AGRICULTURE

Forest Service

36 CFR Part 211

Appeal of Decisions Concerning the National Forest System

AGENCY: Forest Service, USDA.

ACTION: Final rule.

SUMMARY: This rule makes a technical change in the present Forest Service administrative appeal procedures to make explicit that legible United States Postal Service (USPS) postmarks take precedence in determining time of filing. The change is necessary to achieve consistent interpretation. The final rule is issued after consideration of public comment received on the interim rule published in the **Federal Register** of March 17, 1986 (51 FR 9010).

EFFECTIVE DATE: This rule is effective June 3, 1986.

FOR FURTHER INFORMATION CONTACT: Larry Hill, Acting Staff Assistant, National Forest System Staff, Forest Service, USDA, P.O. Box 2417, DC 20013, (202) 382-9349.

SUPPLEMENTARY INFORMATION:

Background

This amendment to Forest Service appeal procedures makes clear that when officials determine timeliness under 36 CFR 211.18(c)(4), legible USPS postmarks shall take precedence over "other evidence of mailing." Only where the USPS postmark is illegible or missing will "other evidence of mailing" be used to determine timeliness.

This action is basically a technical clarification of the rule and does not represent a change in Agency policy or intended procedures.

Analysis of Public Comment

The interim rule generated only one response concerning clarification of the definition of "filing". It was considered in the final rule language.

The response is available for review at the Office of the Deputy Chief, National Forest System, Forest Service, USDA, Room 4211, South Agriculture Building, 12th and Independence Avenues SW., Washington, DC 20250, telephone (202) 382-9346.

Regulatory Impact

Because of its technical nature, it has been determined that this rule is exempt from review procedures required by E.O. 12291. The rule will have no effect on the Nation's economy, or substantial numbers of individuals or businesses, or on the quality of the human environment. The rule does not contain an information collection or recordkeeping requirement as defined in the Paperwork Reduction Act of 1980.

List of Subjects in 36 CFR Part 211

Administrative practice and procedure, National forests.

PART 211—ADMINISTRATION [AMENDED]

Therefore, for the reasons set forth above, Subpart B—Appeal of Decisions Concerning the National Forest System, of Part 211—Administration of Title 36 of the Code of Federal Regulations is amended as follows:

1. The authority citation for Part 211 is added to read as follows, and all other authority citations which appear throughout Part 211 are removed:

Authority: 30 Stat. 35, as amended, sec.1, 33 Stat. 628 (16 U.S.C. 551,472).

Subpart B—Appeal of Decisions Concerning the National Forest System

2. Revise paragraph (c)(4) of § 211.18 to read as follows:

§ 211.18 Appeal of decisions of forest officers.

* * * * *

(c) * * *

(4) When determining time of filing, Reviewing Officers shall give precedence to United States Postal Service (USPS) postmarks over other evidence of timely filing. Filing is defined as either mailing or delivery of the appropriate documents. If documents are delivered by means other than the USPS, date of receipt determines time of filing. If the date of mailing cannot be determined from a legible USPS postmark, the Reviewing Officer may accept other evidence of timely filing. Weekends or Federal holidays are included in computing the time allowed for filing, but when the filing time would expire on a weekend or holiday, the filing time is extended to the end of the next business day.

* * * * *

Dated: May 23, 1986.

Peter C. Myers,

Assistant Secretary, Natural Resources and Environment.

[FR Doc. 86-12367 Filed 6-2-86; 8:45 am]

BILLING CODE 3410-11-M

POSTAL SERVICE

39 CFR Part 111

Domestic Mail Manual; Eligibility To Mail Issues of a Publication at Second-Class Rates

AGENCY: Postal Service.

ACTION: Final rule.

SUMMARY: This final rule change adds a new section to the Domestic Mail Manual to incorporate changes in the Domestic Mail Classification Schedule (DMCS) concerning the eligibility requirements for entry into second-class mail of multiple "issues" of a single publication that are regularly published on the same day. Amendments to other sections of the Domestic Mail Manual are also being implemented to carry forth the intent of the Postal Rate Commission's (Commission) recommended decision in Docket No. C85-1, approved by the Governors of the Postal Service (Governors) on March 3, 1986, that publications identified in the administrative record as "Plus" publications be considered separate publications, whether called "issues" or "editions".

EFFECTIVE DATE: June 8, 1986.

FOR FURTHER INFORMATION CONTACT: Ms. Cheryl Beller, (202) 268-5166.

SUPPLEMENTARY INFORMATION: On April 2, 1986, the Postal Service published in the **Federal Register**, for comment, proposed changes in sections of the Domestic Mail Manual pertaining to issues and editions of second-class publications. 51 FR 11324-27. The changes were proposed to implement new section 200.0123 DMCS which provides that, for purposes of second-class eligibility and postage, an "issue" of a newspaper or other periodical shall be deemed to be a separate publication if it is published at a regular frequency on the same day as another regular "issue" of the same publication, and it is distributed to more than (i) 10 percent nonsubscribers, or (ii) twice as many nonsubscribers as the other issue on that same day, whichever is greater. As explained in the supplementary information, the proposed rule was phrased as "more than (i) . . . *and* (ii)", for greater ease of understanding. 51 FR 11325. Interested persons were invited to submit comments on the proposed changes by May 2, 1986.

Written comments were received from one third-class mailer. The commenter supported the proposed changes and also suggested that certain portions of the affected regulations be further refined and clarified to more closely reflect the intent of the DMCS change. Specifically, the commenter suggested simplifying proposed PS Form 3541-CX by including on it instructions to mailers to report the circulation figures for the issue with the lesser nonsubscriber distribution in the portion of Part A pertaining to "Issue #1" and the figures for the issue with the greater nonsubscriber distribution in the portion pertaining to "Issue #2". This would automatically establish Issue #1 as a regular issue and focus attention on the question of whether Issue #2 must be treated as a separate publication. In addition, the commenter suggested that the term "nonsubscriber copies" be defined on the form to conform to the text of DMM section 425.225b.

We have modified the commenter's suggestion and will require designation of Issue #1 as the one with the lesser nonsubscriber distribution. This will automatically identify Issue #2 as the one with the greater nonsubscriber distribution and will simplify the task of identifying the "parent periodical" and determining whether the issue with the greater nonsubscriber circulation should be treated as a separate publication.

We have not gone as far as the commenter has suggested in clarifying the term "nonsubscriber" on PS Form 3541-CX because of our desire to keep the form as uncomplicated as possible. Postal Service personnel are being instructed to interpret the term consistently with DMM section 422.221.

The commenter also suggested that the Postal Service further clarify the regulations pertaining to the records that are necessary to substantiate eligibility for second-class mail privileges of those publications which are determined to be separate publications under the new regulations. We believe that the regulations themselves, and current related DMM regulations pertaining to maintenance and verification of appropriate publisher records, are sufficient to ensure compliance with the intent and purpose of the Commission and the Governors relative to establishing independent second-class eligibility.

Finally, section 425.2 has been revised to make it clear that the restrictions on issues and editions therein apply only to eligibility for second-class rate status.

Accordingly, the Postal Service hereby adopts the following final regulations on this subject as amendments to the Domestic Mail Manual, which are incorporated by reference in the Code of Federal Regulations. See 39 CFR 111.1.

List of Subjects in 39 CFR Part 111

Postal Service.

PART 111—[AMENDED]

1. The authority for 39 CFR Part 111 continues to read as follows:

Authority: 5 U.S.C. 552(a); 39 U.S.C. 101, 401, 404, 407, 408, 3001–3011, 3201–3219, 3403–3405, 3621, 5001; 42 U.S.C. 1973cc–13, 1973cc–14.

PART 4—SECOND-CLASS MAIL

422.2 General Publications

2. Revise 422.221 to read as follows:

.22 Circulation Requirements

.221 List of Subscribers. General publications must have a legitimate list of subscribers who have paid or promised to pay, at a rate above a nominal rate, for copies to be received during a stated time. Records for subscriptions to a publication which are obtained in conjunction with subscriptions to another publication or other publications must be maintained in such a manner that individual subscriptions to each publication, by title, can be substantiated and verified. Persons whose subscriptions are obtained at a nominal rate (see 422.222) shall not be included as a part of the legitimate list of subscribers. Commingled copies sent in fulfillment of subscriptions obtained at a nominal rate must be charged with postage at regular rates (see 411.21 and 411.4).

422.6 Requester Publications

3. Revise 422.6d to read as follows:

d. Effective October 1, 1982, the publication must have a legitimate list of persons who request the publication, and 50 percent or more of the copies of the publication must be distributed to persons making such requests. Subscription copies of the publication which are paid for or promised to be paid for, including those at or below a nominal rate, may be included in the determination of whether the 50 percent request requirement is met. Persons will not be deemed to have requested the publication if their request is induced by a premium offer or by receipt of material consideration. Records of requests for a publication which are obtained in conjunction with subscriptions or requests for another publication or other publications must be maintained in such a manner that individual requests for the publication, by title, can be substantiated and verified. Requests which are more than three years old will not be considered to meet this requirement.

4. Revise 425.2 to read as follows:

425.2 Issues and Editions

.21 General. Issues and editions of a second-class publication may be mailed at the applicable second-class rates in 410, provided they exhibit the continuity required in 421.1 and satisfy the additional requirements in 425.22 and 425.23.

.22 Issues.

.221 Issues must be published in accordance with the publication's stated frequency (see 421.22).

.222 The publication of regular issues of general and requester publications must be reflected in the identification statement (455.2) and subscription proce. In the case of requester publications, copies must be distributed to requesters in accordance with 422.6d.

.223 Extra issues, not reflected in the publication's stated frequency, publishd for the purpose of communicating news and information received too late for insertion in the regular issue, but not for advertising purposes, may occasionally be mailed at second-class rates. The original entry post office must be notified in writing of such issues before they are mailed.

.224 For second-class purposes, issues may contain annual reports, directories, lists, and similar texts as a part of the contents. Copies of such issues shall not bear designations indicating they are separate publications such as annuals, directories, catalogs, yearbooks, or other types of separate publications. Such issues must bear the publication name as required by 455.1 and be included in the regular annual subscription price.

.225 An "issue" of a newspaper or other periodical shall be deemed to be a separate publication, for postal purposes, and must independently meet the applicable second-class eligibility qualifications in 421.2 through 421.4 and 422, when the following conditions are met:

a. It is published at a regular frequency, such as once each week, on the same day as another regular "issue" of the same publication, and

b. More than 10% of the total number of its copies are distributed to nonsubscribers to the other regular issue published on that day, AND the number of copies distributed to people who do not subscribe to the other issue is more than twice the number of copies of the other regular "issue" published on the same day which are distributed to nonsubscribers.

.23 Editions

.231 Individual issues may be mailed at second-class rates in editions such as demographic, morning or evening editions. Subscribers and requesters will routinely receive no more than one edition of any issue.

.232 Extra editions may be mailed at second-class rates for the purpose of communicating additional news and information received too late for insertion in the regular edition. Such editions may not be intended for advertising purposes.

.233 Editions may differ in content, but not to the extent that they constitute separate and independent publications. Separate publications will not be accepted for mailing as editions of another publication.

5. Revise 444.1 to read as follows:

444.1 Change in Title, Frequency, or Office of Publication

An application for reentry must be filed on Form 3510, Application for Additional Entry or Reentry of Second-Class Publication, whenever the name, frequency of issuance, location of the known office of publication, or qualification category (see 422) is changed. When the name or frequency of issuance of a publication is changed, a Form 3510 must be filed at the post office of original entry with two copies of the publication showing the new name or frequency. When the frequency is being changed to include more than one regular "issue" on any day, PS Form 3541–CX must be completed by the publisher and submitted with Form 3510.

BILLING CODE 7710-12-M

U.S. POSTAL SERVICE

SECOND-CLASS CERTIFICATION FOR MULTIPLE ISSUES ON THE SAME DAY

INSTRUCTIONS

1. Complete this form and attach it to Form 3510, Application for Additional Entry, Reentry or Special Rate Request for Second-Class Publication, when the frequency of a second-class publication is being changed to include more than one "Issue on any day *(see 444.1, DMM)*.
2. This form must also be submitted to each office of mailing with all Forms 3541 and 3541-A for each "Issue" of a second-class publication that is regularly published on the same day as another "Issue" of the same publication.
3. The figures reported must be for the "Issues" published on the same day and must include all copies of all editions of the "Issues" identified as Issues No. 1 and No. 2 which are circulated through the mails and by all other methods of distribution.

PART A – TO BE COMPLETED BY PUBLISHER/AGENT

Title of Publication	USPS Number	Date of Issue

ISSUE No. 1 (The issue distributed to the smaller number of nonsubscribers.)		Vol. Issue Number
1a. Total number of copies of issue distributed by all means.		1a.
1b. Total number of copies of issue distributed to NONSUBSCRIBERS. (See DMM 422.221)		1b.
1c. Percent of copies distributed to nonsubscribers (decimal format) 1b. divided by 1a. =		1c.
1d. Convert 1c. to percent format: (i.e., 17 X 100 = 17%)	1c. X 100 =	1d. %

ISSUE No. 2		Vol. Issue Number
2a. Total number of copies of issue distributed by all means.		2a.
2b. Total number of copies of issue distributed to NONSUBSCRIBERS to the other issue.		2b.
2c. Percent of copies distributed to nonsubscribers (decimal format) 2b. divided by 2a. =		2c.
2d. Convert 2c. to percent format: (i.e., 17 X 100 = 17%)	2c. X 100 =	2d. %

I certify that the information furnished on this form is correct.	Signature of Publisher/Agent required

PART B – TO BE COMPLETED BY ENTRY POST OFFICE

Post Office and State of Mailing

INSTRUCTIONS

1. Check Part A to be sure the publisher has included circulation figures for the issue with the smaller nonsubscriber distribution in the section for Issue No. 1.
2. If the data on this form indicates that "Issue" No. 2 is a separate publication, that "Issue" may not be mailed at the second-class rates under the authorization granted to the publication named in PART A.
3. It must instead independently meet the applicable second-class eligibility qualifications in 421.2 through 421.4 and 422, DMM, or be mailed at third- or fourth-class rates.

Copy the figures for 1b, 2b and 2d furnished by the publisher in PART A in the corresponding spaces below. You must calculate 1e below using the publisher's figures.

1b. _____ X 2 = _____ 1e.

For purposes of determining eligibility to mail at second-class rates.

ISSUE No. 2 will be treated as a SEPARATE PUBLICATION if 2b. is greater than 1e. and 2d. is greater than 10%.

2b. _____ 1e. _____ 2d. _____

Based on the data on this form, ISSUE No. 2 is a separate publication: ☐ YES ☐ NO

PS Form **3541-CX**, Apr. 1986

Exhibit 484a

BILLING CODE 7710-12-C

6. Add new section 484 as follows:

484 Statement of Publication of More Than One Issue on the Same Day

The publisher must submit PS Form 3541-CX whenever the publisher desires to mail an "issue" that is regularly published on the same day as another "issue" of the same publication under a single second-class permit granted to the parent publication. This form is necessary to determine whether either "issue" will be treated as a separate publication for purposes of determining eligibility to mail at the second-class rates (see 425.225). The publisher must attach the completed form(s) to the mailing statement(s) submitted to each office where mailings are made. A sample of PS Form 3541-CX is shown in Exhibit 484a.

A transmittal letter making these changes in the pages of the Domestic Mail Manual will be published and will be transmitted to subscribers automatically. Notice of issuance of the transmittal letter will be published in the **Federal Register** as provided in 39 CFR 111.3.

Fred Eggleston,

Assistant General Counsel, Legislative Division.

[FR Doc. 86-12355 Filed 6-2-86; 8:45 am]

BILLING CODE 7710-12-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[FRL-3024-9]

Approval and Promulgation of Implementation Plans; Indiana

AGENCY: U.S. Environmental Protection Agency (USEPA).

ACTION: Final rulemaking.

SUMMARY: The State of Indiana submitted to USEPA Rule 325 IAC 13-2, Motor Vehicle Tampering and Fuel Switching. USEPA is approving this addition to the Indiana State Implementation Plan (SIP) as contributing to the attainment and maintenance of the National Ambient Air Quality Standards (NAAQS) in Indiana.

EFFECTIVE DATE: This final rulemaking becomes effective on July 3, 1986.

ADDRESSES: Copies of this revision to the Indiana SIP are available for inspection at: The Office of the Federal Register, 1100 L Street, NW., Room 8401, Washington, DC.

Copies of the SIP revision, public comments on the notice of proposed rulemaking and other materials relating to this rulemaking are available for inspection at the following addreses: (It is recommended that you telephone Anne E. Tenner, at (312) 886-6036, before visiting the Region V Office.)

U.S. Environmental Protection Agency, Region V, Air and Radiation Branch (5AR-26), 230 South Dearborn Street, Chicago, Illinois, 60604

U.S. Environmental Protection Agency, Public Information Reference Unit, 401 M Street, SW., Washington, DC 20460

Indiana Air Pollution Control Division, Indiana State Board of Health, 1330 West Michigan Street, Indianapolis, Indiana 46206

FOR FURTHER INFORMATION CONTACT: Anne E. Tenner (312) 886-6036.

SUPPLEMENTARY INFORMATION: On July 31, 1985 (50 FR 30960), USEPA proposed approval of Rule 325 IAC 13-2, Motor Vehicle Tampering and Fuel Switching. A detailed discussion of USEPA's action can be found in the notice of proposed rulemaking and the technical support document which is available at USEPA's Region V office.

During the 60 day public comment period, USEPA received no comments on this proposed action.

USEPA reviewed the requirements of 325 IAC 13-2 in relation to the applicable portions of the Clean Air Act and has found that the Indiana anti-tampering provisions are consistent with Section 211 of the Act, and 40 CFR Part 80 Subpart B. As a result, USEPA approves 325 IAC 13-2 as an addition to the Indiana SIP.

USEPA notes that Indiana submitted the regulation without requesting specific emission reduction credits in its air quality attainment and maintenance plans due to implementation of this rule. Although it is not Agency policy to assign specific credits for this activity, USEPA believes that enforcement of this rule is an important part of the efforts to reduce the incidence of vehicle tampering and fuel switching and the related emissions of Carbon monoxide, hydrocarbons and oxides of nitrogen.

The Office of Management and Budget has exempted this rule from the requirements of Section 3 of Executive Order 12291.

Under Section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by (60 days from date of publication). This action may not be challenged later in proceedings to enforce its requirements. (See 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental Protection Agency, Air pollution control, Incorporation by reference, Ozone, Nitrogen dioxide, Lead, Carbon monoxide, Hydrocarbons, Intergovernmental relations.

Note.—Incorporation by reference of the State Implementation Plan for the State of Indiana was approved by the Director of the **Federal Register** on July 1, 1982.

Dated: May 27, 1986.

Lee M. Thomas,

Administrator.

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

Indiana

Title 40 of the Code of Federal Regulations, Chapter I, Part 52, is amended as follows:

1. The authority citation for Part 52 continues to read as follows:

Authority: 42 U.S.C. 7401-7642.

2. Section 52.770 is amended by adding new paragraph (c)(58) as follows:

§ 52.770 Identification of plan.

* * * * *

(c) * * *

(58) On November 13, 1984, Indiana submitted 325 IAC 13-2, Motor Vehicle Tampering and Fuel Switching.

(i) Incorporation by reference.

(A) Indiana Rule 325 IAC 13-2, Promulgated by the State on September 24, 1984.

[FR Doc. 86-12438 Filed 6-2-86; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 52

[FRL-3025-2; NC-017]

Approval and Promulgation of Implementation Plans, North Carolina; 1976 SIP Update

AGENCY: Environmental Protection Agency.

ACTION: Final rule.

SUMMARY: On March 31, 1976, the North Carolina Department of Natural and Economic Resources submitted for EPA's approval an updated version of its State implementation plan (SIP). (North Carolina's original SIP was approved by EPA on May 31, 1972). EPA did not act on the submittal at the time because of the editorial nature of the revisions made for this update. Since the regulations were recodified in the updated version, EPA feels that formal action is now needed to avoid confusion, and today approves the 1976

version of the North Carolina regulations. EPA is also removing 40 CFR 52.1774, which states EPA approval of specific North Carolina compliance schedules, since the schedules are now irrelevant—none has a final compliance date after 1975.

EFFECTIVE DATE: These actions will be effective on August 4, 1986, unless notice is received within 30 days that adverse or critical comments will be submitted.

ADDRESSES: Copies of the materials submitted by North Carolina may be examined during normal business hours at the following locations:

Public Information Reference Unit, Library Systems Branch, Environmental Protection Agency, 401 M Street SW., Washington, DC 20460

Air Programs Branch, EPA, Region IV, 345 Courtland Street NE., Atlanta, Georgia 30365

Division of Environmental Management, North Carolina Department of Natural Resoures and Community Development, Archdale Building, 512 N. Salisbury Street, Raleigh, North Carolina 27611

Office of the Federal Register, 1100 L Street NW., Room 8401, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Janet Hayward, Air Programs Branch, EPA Region IV, at the above address, telephone 404-347-3286 (FTS 257-3286).

SUPPLEMENTARY INFORMATION: In awarding air program support grants to its states for fiscal year 1976, EPA Region IV set as a condition that the grantees should update their SIP to take into account changes that had taken place since the original SIP approval of May 31, 1972 (37 FR 10858). North Carolina complied with an updated SIP submitted on March 31, 1976.

In updating its SIP, the State complied with a directive from the North Carolina legislature that all State agency regulations be put into the same format as part of the North Carolina Administrative Code. The regulation numbering system used for the 1972 SIP, the basis for the regulatory citations found in 40 CFR 52.1774, was replaced with a new one. Also, a number of other editorial changes were made. Most of these changes were made to update titles or dates and require no comment. Three changes merit mention, however.

In the 1972 regulations, Section IV, Emission Control Standards, contained graphs to show allowable emission rates between rates shown in the applicable tables. The 1976 version gave instead an equation to calculate the rates not given in the process weight tables; the actual limits did not change from 1972 to 1976.

Also, ¶ 1.10(1) of the same Section, recodified in the 1976 SIP as 15 NCAC 2D.0503(b), lacked wording found in the 1976 version; this wording is italicized in the following quotation: "When any products or by-products of a manufacturing process are burned for *the same purpose, or in conjunction with any fuel,* the same maximum emissions limitations shall apply." This was apparently to correct an omission in the 1972 version of the regulations. Finally, a new regulation, 15 NCAC 2D.0523, was added for conical burners; this had not been previously submitted for EPA approval and EPA has no record of its having been given public hearing. Accordingly, today's approval action does not apply to regulation 2D.0523.

The following table summarizes the changes which were made in regulation numbering and organization from the 1972 version to the 1976 version of the North Carolina SIP.

1972 No.	Title	1976 No.	Title
I	Definitions	2D.0100	Same
		.0101	Words
		.0102	Phrases.
II-1	Control and prohibition of open burning	2D.0520	Same.
II-1.0	Purpose	2D.0520(a)	Same.
II-1.1, II-1.2	Scope	2D.0520(b)	Same.
II-1.3	Permissible open burning	2D.0520(c)	Same.
II-2	Control and prohibition of visible emissions	2D.0521	Control of visible emissions.
II-2.0	Purpose	2D.0521(a)	Same.
II-2.1	Scope	2D.0521(b)	Same.
II-2.2	Restrictions applicable to existing installations	2D.0521(c)	Installations existing as of July 1, 1971.
II-2.3	Restrictions applicable to new installations	2D.0521(d)	Installations established after July 1, 1971.
II-3	Classification for air contaminant sources	2D.0201	Classification of air contaminant sources.
II-3.0	Purpose	2D.0201(a)	Same.
II-3.1	Scope	2D.0201(b)	Same.
II-4	Registration of air contaminant sources	2D.0202	Same.
II-4.0	Purpose	2D.0202(a)	Same.
II-4.1	Scope	2D.0202(b)	Same.
II-5	Control and prohibition of odorous emissions	2D.0522	Same.
II-5.0	Purpose	2D.0522(a)	Same.
II-5.1	Scope	2D.0522(b)	Same.
II-6	Compliance with emission control standards	2D.0501	Same.
II-6.0	Purpose	2D.0501(a)	Purpose and scope.
II-6.1	Scope		
II-7	Air pollution emergencies	2D.0300	Same.
II-7.0	Purpose	2D.0301	Same.
II-7.1	Episode criteria	2D.0302	Same.
II-7.2	Emission reduction plans	2D.0303	Same.
II-7.3	Preplanned abatement program	2D.0304	Same.
II-7.4	[Title lacking]		
	Table I Emission reduction plan—Alert level	2D.0305	Same.
	T. II Emission reduction plan—Warning level	2D.0306	Same.
	T. III Emission reduction plan—Emergency level	2D.0307	Same.
III	Ambient air quality standards	2D.0400	Same.
III-1.0	Purpose	2D.0401	Same.
III-1.10	Sulfur dioxide	2D.0402	Same.
III-1.11	Sampling and analysis	2D.0402(b)	[Title lacking].
III-1.20	Suspended particulates	2D.0403	Same.
III-1.21	Sampling and anlaysis	2D.0403(b)	[Title lacking].
III-1.30	Carbon monoxide	2D.0404	Same.
III-1.31	Sampling and analysis	2D.0404(b)	[Title lacking].
III-1.40	Photochemical oxidants	2D.0405	Same.
III-1.41	Sampling and analysis	2D.0405(b)	[Title lacking].
III-1.50	Hydrocarbons	2D.0406	Same.
III-1.51	Sampling and analysis	2D.0406(b)	[Title lacking].
III-1.60	Nitrogen dioxide	2D.0407	Same.
III-1.61	Sampling and analysis	2D.0407(b)	[Title lacking].
IV	Emission control standards	2D.0500	Same.

1972 No.	Title	1976 No.	Title
IV-1.00	Purpose	2D.0502	Same.
IV-1.10	Control and prohibition of particuate matter emissions from fuel burning sources.	2D.0503	Control of particulates from fuel burning sources.
IV-1.20	Control and prohibition of particulate matter emissions from wood burning indirect heat exchangers.	2D.0504	Particulates from wood burning indirect heat exchangers.
IV-1.30	Control and prohibition of particulate matter emission from refuse burning equipment.	2D.0505	Control of particulates from refuse buring equipment.
IV-1.40	Control and prohibition of particulate matter from hot mix asphalt plants	2D.0506	Control of particulates from hot mix asphalt plants.
IV-1.50	Control and prohibition of particulate matter emissions from chemical fertilizer manufacturing plants.	2D.0507	Particulates from chemical fertilizer manufacturing plants.
IV-1.60	Control and prohibition of particulate matter from pulp and paper mills	2D.0508	Control of particulates from pulp and paper mills.
IV-1.70	Control and prohibition of the emission of particulate matter from plants engaged in the processing of mica or feldspar.	2D.0509	Particulates from mica or feldspar processing plants.
IV-1.80	Control and prohibition of particulate matter from materials handling in sand, gravel and crushed stone operations.	2D.0510	Particulates: Sand, gravel, crushed stone operations.
IV-1.90	Control and prohibition of particulate matter and sulfur dioxide from lightweight aggregate processes.	2D.0511	Particulates, SO_2 from lightweight aggregate processes.
IV-2.00	Control and prohibition of particulate matter emissions from plants engaged in the finishing of wood products.	2D.0512	Particulates from wood products finishing plants.
IV-2.10	Control and prohibition of particulate matter emissions from Portland cement plants.	2D.0513	Control of particulates from Portland cement plants.
IV-2.20	Control and prohibition of particulate matter emissions from existing ferrous jobbing foundries.	2D.0514	Control of particulates from ferrous jobbing foundries.
IV-2.30	Control and prohibition of particulate matter emissions from miscellaneous industrial processes.	2D.0515	Particulates from miscellaneous industrial processes.
IV-2.40	Control and prohibition of the emission of sulfur dioxide from fuel burning installations.	2D.0516	Sulfur dioxide emissions from fuel burning installations.
IV-2.50	Control and prohibition of sulfur dioxide emissions from plants producing sulfuric acid.	2D.0517	SO_2 emissions from plants producing sulfuric acid.
IV-2.60	Control of hydrocarbon emissions from stationary sources	2D.0518	Same.
IV-2.70	Control of nitrogen dioxide emissions	2D.0519	Same.

The original (1972) regulation numbers given above are cited in the compliance schedules of 40 CFR 52.1774. None of these schedules is still relevant to existing air pollution control activity in North Carolina. Accordingly, EPA is removing them from the Code of Federal Regulations.

Final Action

Since the changes in the 1976 North Carolina regulations are editorial in nature, EPA find it appropriate to approve them without prior proposal. The same holds for the deletion of the obsolete compliance schedules. These are noncontroversial amendments and no adverse comments are anticipated. These actions will be effective 60 days from the date of this **Federal Register** notice unless, within 30 days of its publication, notice is received that adverse or critical comments will be submitted. If such notice is received, this action will be withdrawn before the effect date by publishing two subsequent notices. One notice will withdraw the final action and another will begin a new rulemaking by announcing a proposal of the action and establishing a comment period. If no such comments are received, the public is advised that this action will be effective August 4, 1986.

Under Section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the Unites States Court of Appeals for the appropriate circuit by August 4, 1986. This action may not be challenged later in proceedings to enforce its requirements. (See 307(b)(2).)

Under 5 U.S.C. 605(b) I certify that SIP revisions do not have a significant economic impact on a substantial number of small entities. (See 46 FR 8709.)

The Office of Management and Budget has exempted this rule from the requirements of Section 3 of Executive Order 12291.

Incorporation by reference of the North Carolina State Implementation Plan was approved by the Director of the Federal Register on July 1, 1982.

List of Subjects in 40 CFR Part 52

Air pollution control, Intergovernmental relations, Ozone, Sulfur oxides, Nitrogen dioxide, Lead, Particulate matter, Carbon monoxide, Hydrocarbons.

Dated: May 27, 1986.

Lee M. Thomas,

Administrator.

PART 52—[AMENDED]

Part 52 of Chapter I, Title 40, Code of Federal Regulations, is amended as follows:

1. The authority citation for Part 52 continues to read as follows:

Authority: 42 U.S.C. 7401–7642.

Subpart II—North Carolina

2. In § 52.1770 is amended by adding paragraph (c)(41) as follows:

§ 52.1770 Identification of plan.

* * * * *

(c) * * *

(41) Updated air pollution control regulations submitted on March 31, 1976, by the North Carolina Department of Natural and Economic Resources. (No action is taken to approve regulation 2D.0523.)

(i) Incorporation by reference

(A) NCAC Title 15, Dept. of Natural and Economic Resources, Chapter 2, Environmental Management, Recodification and other editorial revisions in regulations, effective February 1, 1976.

(ii) Other material—None

§ 52.1774 [Removed and Reserved]

3. Section 52.1774, Compliance schedules, is removed and reserved.

[FR Doc. 86–12440 Filed 6–2–86; 8:45 am]

BILLING CODE 6560–50–M

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40 CFR Part 52

[FRL–3025–1; TN–007]

Approval and Promulgation of Implementation Plans, Tennessee; 1982 Carbon Monoxide Nonattainment Plan, for Nashville-Davidson County

AGENCY: Environmental Protection Agency.

ACTION: Final rule.

SUMMARY: EPA today announces its approval of the 1982 State Implementation Plan revisions which the State of Tennessee submitted on June 14, 1985, for the Nashville-Davidson County carbon monoxide nonattainment area. These revisions meet the requirements of the Clean Air Act (CAA) and EPA policy. The intended purpose of this action is to provide for

attainment of the National Ambient Air Quality Standards for carbon monoxide (CO), as required under Part D of Title I of the Clean Air Act. EPA is also removing the construction ban imposed earlier under the provisions of Section 110(a)(2)(I) of the Act.

DATES: This action will be effective August 4, 1986, unless notice is received within 30 days that adverse or critical comments will be submitted.

ADDRESSES: Send any comments to Waymond Blackmon, EPA Region IV, Air Programs Branch, 404/881-2864 or FTS 257-2864. You may inspect copies of the submittal and EPA's evaluation during normal business hours at the following locations:

EPA Regional IV, Air Programs Branch, 345 Courtland Street NE., Atlanta, Georgia 30365

Tennessee Air Pollution Control Division, Customs House, 4th Floor, 710 Broadway, Nashville, Tennessee 37219-5403

Copies of the submittal can be inspected during normal business hours at the following locations:

Public Information Reference Unit, Library Systems Branch, Environmental Protection Agency, 401 M Street SW., Washington, DC 20460

The Office of the Federal Register, 1100 L Street, NW., Room 8401, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Waymond Blackmon, EPA, Region IV, Air Programs Branch, 404/881-2864 or FTS 257-2864.

SUPPLEMENTARY INFORMATION: As detailed in the proposal notice of February 3, 1983 (48 FR 5058), the State of Tennessee submitted its initial SIP revision for the Metropolitan Nashville-Davidson County CO nonattainment area on February 13, 1979. The State requested that EPA extend the attainment date of the CO standard in this area to December 31, 1987. EPA granted this request and conditionally approved the initial plan revison on August 13, 1980 (45 FR 53809).

Tennessee submitted its 1982 CO SIP revision for Nashville-Davidison county on June 30, 1982, and EPA proposed to disapprove it on February 3, 1983. Those revisions submitted by the State/local agency failed to provide fully approvable plans for Transportation Control Measures (TCMs), Basic Transportation Needs (BTNs), Resource Commitments, Reasonable Further Progress (RFP) and an acceptable Inspection and Maintenance (I/M) program. For a full discussion of these SIP revisions and EPA's evaluation of them, the reader may consult the February 3, 1983 (48 FR 5058), notice proposing disapproval of the CO plan and the final disapproval notice of April 5, 1984 (49 FR 13522), which stated the Agency's intent to impose funding restrictions under Section 176(b) of the Act and imposed a ban on construction of major new or modified stationary sources of carbon monoxide in the Nashville-Davidson County nonattainment area Sections 173(4) and 110(a)(2)(I) of the Act. On July 31, 1984 (49 FR 30466), EPA removed the funding restrictions of Section 176(b) and the construction ban imposed under Section 173(4); that action was based upon EPA's receipt of an approved, signed contract for the operation of the I/M program. Stationary source construction sanctions under Section 110(a)(2)(I) remained in place.

On September 13, 1985 (50 FR 37363), EPA announced final approval of the transportation control measures portion of the submittal upon receiving adopted contingency measures as required for full approval by EPA. Implementation of the I/M program started January 2, 1985, enabling EPA to give full approval to the 1982 CO SIP for Nashville-Davidson County area.

Carbon Monoxide (CO) SIP

CO violations are caused primarily by automobile emissions. They generally occur in the areas around major intersections, or in central business districts, where vehicles tend to idle for relatively long periods. EPA calls these problem areas "hot spots." The State's submittal combines a mix of mobile source strategies necessary to project attainment of the carbon monoxide standard. It is divided into seven sections:

1. Emission Inventories.
2. Modeling and Monitoring.
3. Stationary Source Controls.
4. Inspection and Maintenance (I/M).
5. Reasonable Further Progress (RFP).
6. Basic Transportation Needs (BTNs).
7. Resource Commitments.

Emission Inventory

The emission inventory for carbon monoxide (CO) was done using a typical winter workday and a three-month average temperature of 38.8° F. The inventory was done for a base year of 1982 with projection through 1987. The mobile source inventory was developed by the Metropolitan Planning Council (MPC) and the stationary source inventory was developed by the Metropolitan Health Department (MHD). The emission inventory was compiled pursuant to appropriate EPA policies and procedures. Furthermore, there were no point sources of CO greater than 1000 TPY.

Modeling and Monitoring

The State's submittal contains a detailed modeling analysis to demonstrate attainment of the CO standard by 1987 at local hot spot intersections. Fifty-one intersections were screened, and twenty-two were found to need further investigation. Upon further screening, eleven were found to need a detailed modeling analysis to determine what type of strategies would be needed to reduce the ambient CO emissions to an acceptable level. These eleven were analyzed with the Intersection Midblock Model (IMM) program. The IMM uses meteorological inputs as well as traffic parameters and emission factors for mobile sources to predict one and eight-hour concentrations of CO. These concentrations are then compared to the one and eight-hour standards for CO. Using IMM, the State demonstrated that attainment would be achieved at four of the intersections in 1980. Of the remaining seven, three were demonstrated to attain the standards by 1983 before any reduction strategies could be put into place. This left only four intersections where TCMs were needed to attain the CO standard. These four intersections were modeled using strategies of (a) road alignment, (b) throat widening, and (c) the optimization of signalization for the downtown area. From the SIP submittal it became apparent that two of these intersections would not come into compliance unless the projected improvements were made. These two intersections are Harding Road with Woodmont/White bridge, and Broadway with Eighth Avenue. These two intersections required straightening the alignment and signal optimization project to attain the CO standard. EPA proposed disapproval on February 3, 1983 (48 FR 5058) of the signal optimization program, because it was not being implemented. Subsequently, the signal optimization program has been reevaluated and its implementation is under way. EPA has concurred with these revisions. The TCMs portion of the submittal was approved on September 13, 1985 (50 FR 37363).

Stationary Source Controls

EPA policy requires that regulations for the RACT control of 1000 TPY stationary sources of CO be submitted with the 1982 SIP revision. The State of Tennessee's CO emission inventory for the Nashville-Davidson county area did not identify any source greater than 1000

TPY. Since EPA policy only requires controlling of sources greater than 1000 TPY, no stationary source RACT regulations were required to be submitted from the Metropolitan Health Department.

Inspection and Maintenance (I/M)

On April 5, 1984 (49 FR 13522), EPA disapproved Tennessee's 1982 revision to its Carbon Monoxide State Implementation Plan for the Metropolitan Nashville-Davidson county area, because of the failure to enter into a contract for operation of an I/M program. The plan submitted by the state/local agency failed to provide an acceptable I/M program. Disapproval of the CO portion of the SIP invoked a ban on the construction of major new or modified stationary sources of carbon monoxide in the Nashville-Davidson county nonattainment area as required by Section 110(a)(2)(I) of the Act (42 U.S.C. 7410(a)(2)(I)).

EPA also found that Tennessee's 1979 CO SIP for Nashville was not being implemented because the enforcement mechanism for the I/M program had not been adopted. This finding also imposed a moratorium on construction of major new or modified sources of CO in the nonattainment area under Section 173(4) of the Act. The 173(4) moratorium prohibited the issuance of any new permits to affected sources, including those which had already made a complete application before April 5, 1984, the date on which this restriction was imposed. The Agency's intent to place restrictions on grant funds under Section 176(b) of the Act was also proposed in the August 3, 1983, notice (48 FR 35314), and finalized in the April 5, 1984, notice (49 FR 13522).

However, because the issue of the appropriate formula for applying these restrictions had not been resolved, no actual funding sanctions were imposed. On May 3, 1984, EPA received the approved, signed contract for the operation of an I/M program for Nashville-Davidson County, Tennessee (start-up of I/M program in Nashville was January 2, 1985). Since this submittal demonstrated a good faith effort toward implementing an I/M program in an expeditious manner, EPA removed the construction moratorium and funding restriction imposed under 173(4) and 176(b) of the Act, respectively. (49 FR 30466, July 31, 1984)

Sanctions imposed under Section 110(a)(2)(I) of the Act remained in place until EPA could take final action on the entire CO SIP; this prohibited the issuance of permits for which a complete application had not been submitted as of April 5, 1984. Today's action to approve the entire CO SIP will revoke the sanctions imposed under Section 110(a)(2)(I) of the Act.

Reasonable Further Progress (RFP)

The SIP contained RFP graphs for the intersections that needed TCMs to attain the CO standard. These appeared to be reasonable, except that the TCMs that were adopted were not implemented because of the failure of the one-cent tax referendum and personnel shortages. Subsequently, the measure requiring return to the 1980 level of service for transit has been replaced with a "two-cent gas tax" equivalent and the ridesharing program measure from the contingency package.

Also, the signal optimization program has been reevaluated and its implementation is under way. EPA has concurred with these revisions. The TCMs portion of the submittal was approved on September 13, 1985 (50 FR 37363).

Basic Transportation Needs (BTN)

The BTN for Nashville was developed by the Metropolitan Planning Council in conjunction with the Citizen Advisory Committee (CAC) and the Technical Coordinating Committee (TCC). Working together these groups determined and selected a transportation system that would meet and enhance the transportation system's goals of increasing efficiency, quality, and mobility. An integral part of the BTN involved adopting and selecting the TCM strategies for the area. In particular, the low-cost transit emphasis package of the TCM analysis was being used to enhance the BTN for Nashville. Failure of the one-cent tax referendum placed the BTN in limbo because the low-cost transit improvements could not be implemented. EPA proposed in the February 3, 1983, **Federal Register**, to disapprove the BTN portion of the CO SIP. In order for the BTN to be approved, EPA asked the MPC to demonstrate that they could meet these requirements without implementing the low-cost transit improvements. The MPC could also substitute measures for those that were lost because of the failure of the one-cent gas tax.

The low-cost Transit Emphasis Package consisted of the improved bus speeds, subsidized employee transit costs, variable work hours, study of the transit fare structure, two-cent gas tax equivalent and traffic flow improvements (signal optimization project and intersection improvements). Since that time, Nashville has submitted the revised Transportation Control Plan portion and has satisfied EPA's TCP requirements by substituting measures from the contingency plan for those measures not implemented. (See 50 FR 37363 for approval of TCM portion of CO SIP.)

Resource Commitments

On September 22, 1982, EPA received a copy of a letter sent from the MPC to the MHD indicating that the one-cent gasoline sales tax referendum did not pass. It was EPA's understanding that this would prevent the implementation of the transit strategies adopted for the SIP. Furthermore, the letter stated that the Metropolitan Traffic and Parking Commission was not implementing the signal optimization program because of personnel shortages. With regard to the one-cent gas tax referendum, the MPC would have to substitute measures to replace those that would not be carried out because of the loss of revenue. EPA suggested that the MPC consider substituting measures from its contingency plan. Since that time, Nashville has submitted the revised TCP portion and has satisfied EPA's transportation control plan requirements by substituting measures from the contingency plan.

EPA is publishing this action without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. This action will be effective 60 days from date of publication unless, within 30 days of its publication, notice is received that adverse or critical comments will be submitted.

If such notice is received, this action will be withdrawn before the effective date by publishing two subsequent notices. One notice will withdraw the final action and another will begin a new rulemaking by announcing a proposal of the action and establishing a comment period. If no such comments are received, the public is advised that this action will be effective August 4, 1986.

Final Action. Based upon the above discussions, EPA today is fully approving the 1982 Carbon Monoxide (CO) SIP revisions for Nashville-Davidson County, Tennessee, and revoking the moratorium imposed under the provisions of Section 110(a)(2)(I) of the Clean Air Act on the construction of major new or modified sources of carbon monoxide in the nonattainment area.

Under 5 U.S.C. 605(b), I certify that this SIP revision will not have significant economic impact on a substantial number of small entities.

The Office of Management and Budget has exempted this rule from the

requirements of Section 3 of Executive Order 12291.

Under Section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by August 4, 1986. This action may not be challenged later in proceedings to enforce its requirements. (See 307(b)(2).)

Incorporation by reference of the State Implementation Plan for the State of Tennessee was approved by the director of the Federal Register on July 1, 1982.

List of Subjects in 40 CFR Part 52

Air pollution control, Intergovernmental relations, Carbon monoxide, Incorporation by reference.

Dated: May 27, 1986.

Lee M. Thomas,

Administrator.

PART 52—[AMENDED]

Part 52 of Chapter I, Title 40, Code of Federal Regulations, is amended as follows:

1. The authority citation for Part 52 continues to read as follows:

Authority. 42 U.S.C. 7401–7642.

Subpart RR—Tennessee

2. Section 52.2220 is amended by adding paragraph (c) (56) as follows:

§ 52.2220 Identification of plan.

* * * * *

(c) * * *

(56) 1982 revisions in the Part D CO SIP for the Nashville-Davidson County nonattainment area (except TCM portion approved on September 13, 1985), submitted on June 30, 1982, and June 14, 1985.

(i) Incorporation by reference.

(A) Metropolitan Health Department Pollution Control Division Regulation No. 8 for Inspection and Maintenance (I/M) adopted on May 13, 1981; and revised on June 12, 1985, and February 15, 1984.

(B) Metropolitan Nashville and Davidson County's Carbon Monoxide Reasonable Further Progress (RFP) curve adopted on May 8, 1985.

(ii) Other Material.

(A) Narrative adopted June 16, 1982.

(B) Public awareness program mechanics training program adopted May 8, 1985.

§ 52.2225 [Removed]

3. Section 52.2225, Control Strategy: Carbon monoxide and ozone, is removed.

[FR Doc. 86–12442 Filed 6–2–86; 8:45 am]

BILLING CODE 6560–50–M

40 CFR Part 704

[OPTS–82028; FRL–3024–2]

Reporting and Recordkeeping Requirements; Technical Amendments

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; Technical amendment.

SUMMARY: EPA has learned that a list of substances, which are the subject of a chemical-specific rule, is incorrectly set out in the Code of Federal Regulations. Some of the substances on the list have been assigned the Chemical Abstract Service (CAS) Registry numbers of other substances on the list and vice versa. This notice will revise the list of substances by correctly setting out the list and by placing the list of substances in CAS number order. This is a non-substantive change that does not require public comment.

DATE: This final rule is effective on June 3, 1986.

FOR FURTHER INFORMATION CONTACT: Edward A. Klein, Director, TSCA Assistance Office (TS–799), Office of Toxic Substances, Environmental Protection Agency, Room E–543, 401 M Street, SW., Washington, DC 20460, Toll free: (800–424–9065), In Washington, DC: (554–1404), Outside the USA: (Operator–202–554–1404).

List of Subjects in 40 CFR Part 704

Hazardous materials, Imports, Environmental protection, Reporting and recordkeeping requirements.

Dated: May 22, 1986.

Don Clay,

Director, Office of Toxic Substances.

PART 704—[AMENDED]

Therefore, 40 CFR Part 704 is amended as follows:

1. The authority citation continues to read as follows:

Authority: 15 U.S.C. 2607(a).

2. Section 704.83 is amended by revising paragraph (b) to read as follows:

§ 704.83 Chlorinated naphthalenes.

* * * * *

(b) *Substances for which reports must be submitted.*

CAS registry number	Chemical substance
90–13–1	Naphthalene, 1-chloro-
91–58–7	Naphthalene, 2-chloro-
1321–64–8	Naphthalene, pentachloro-
1321–65–9	Naphthalene, trichloro-
1335–87–1	Naphthalene, hexachloro-
1335–88–2	Naphthalene, tetrachloro-
1825–30–5	Naphthalene, 1,5-dichloro-
1825–31–6	Naphthalene, 1,4-dichloro-
2050–69–3	Naphthalene, 1,2-dichloro-
2050–72–8	Naphthalene, 1,6-dichloro-
2050–73–9	Naphthalene, 1,7-dichloro-
2050–74–0	Naphthalene, 1,8-dichloro-
2050–75–1	Naphthalene, 2,3-dichloro-
2065–70–5	Naphthalene, 2,6-dichloro-
2198–75–6	Naphthalene, 1,3-dichloro-
2198–77–8	Naphthalene, 2,7-dichloro-
2234–13–1	Naphthalene, octachloro-
25586–43–0	Naphthalene, chloro-
32241–08–0	Naphthalene, heptachloro-
70776–03–3	Naphthalene, chloro derivatives.

* * * * *

[FR Doc. 86–12380 Filed 6–2–86; 8:45 am]

BILLING CODE 6560–50–M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 21, 74, 78, and 94

[Gen Docket No. 82–334; FCC 86–203]

Establishment of a Spectrum Utilization Policy for the Fixed and Mobile Services' Use of Certain Bands Between 947 MHz and 40 GHz

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This action disposes of a Petition for Limited Reconsideration requesting review of decisions made in the *Second Report and Order (2nd R&O)* in General Docket 82–334, FCC 85–49 (50 FR 7338; February 22, 1985) which provided expanded access to the 31.0–31.3 GHz (31 GHz) band. The petition requested that certain changes be made in the technical standards which govern mobile use of the band; and this action partially grants the request by relaxing restrictions on antenna standards in order to permit more convenient mobile operations.

EFFECTIVE DATE: June 4, 1986.

ADDRESS: Federal Communications Commission, 1919 M Street, NW, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Donald Draper Campbell, Office of Engineering and Technology, Spectrum Engineering Division, Frequency Allocations Branch, tele: 202–653–8113.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Memorandum Opinion and Order* in General Docket 82–334, FCC 86–203, Adopted April 21, 1986, and Released April 28, 1986.

The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230),

1919 M Street, NW, Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Service, (202) 857–3800, 2100 M Street, NW, Suite 140, Washington, DC 20037.

Summary of Memorandum Opinion and Order

1. In this *Memorandum Opinion and Order (MO&O)*, we are considering a Petition for Limited Reconsideration filed by M/A–COM, Inc. (M/A–COM) with regard to the *2nd R&O*. The *2nd R&O* dealt exclusively with operations in the 31.0 to 31.3 GHz (31 GHz) band. M/A–COM requests modification of the antenna standard and power limit to accommodate portable/mobile operations. Examples of such applications include mobile video cameras for use in filmmaking and control of industrial robots.

2. The Commission finds merit in M/A–COM's petition and accordingly is exempting most mobile operations from any antenna requirements; however, we are retaining the transmitter output power limit of 50 mW in lieu of an alternative limit based on EIRP. This action will allow manufacturers flexibility in design of systems for mobile use while minimizing the risk of harmful interference.

Ordering Clauses

3. Accordingly, it is ordered that, under the authority contained in 47 U.S.C. 4(i), 301 and 303(r), the *Petition for Limited Reconsideration* file by M/A–COM, Inc. is granted in part and denied in part for the reasons stated above.

4. It is further ordered, that under the authority contained in 47 U.S.C. 154(i), 154(j) and 220, Parts 21, 74, 78 and 94 of the Commission's Rules are amended effective June 4, 1986, as shown below.

List of Subjects

47 CFR Part 2

Allocations.

47 CFR Part 21

Communication common carriers, Point-to-point microwave, Transmission.

47 CFR Parts 74, 78, 94 and 95

Point-to-point microwave.

Rule Changes

5. Parts 21, 74, 78 and 94 of Title 47 of the Code of Federal Regulations are amended as follows:

PART 21—DOMESTIC PUBLIC FIXED RADIO SERVICES (OTHER THAN MARITIME MOBILE)

6. The authority citation for Part 21 continues to read as follows:

Authority: Sec. 4, 303, 48 Stat. 1066, as amended; 47 U.S.C. 154, 303, unless otherwise noted.

7. Section 21.108 is amended by revising the entry for the frequency band 31,000 to 31,300 MHz in the table and adding a new footnote 3 to the table in paragraph (c) as follows:

§ 21.108 Directional antennas.

* * * * *

(c) * * *

Frequency (MHz)	Category	Maximum beamwidth to 3 dB points (included angle in degrees)	Minimum antenna gain (dBi)	Minimum radiation suppression to angle in degrees from centerline of main beam in decibels						
				5 to 10	10 to 15	15 to 20	20 to 30	30 to 100	100 to 140	140 to 180
31,000 to 31,300 [3]	NA	[1] 4.0	38.0							

[1] Digital Termination User Station antennas shall meet performance Standard B and have a minimum antenna gain of 34 dBi.

* * * * * * *

[3] Mobile, except aeronautical mobile, stations need not comply with these standards.

* * * * *

PART 74—EXPERIMENTAL, AUXILIARY AND SPECIAL BROADCAST AND OTHER PROGRAM DISTRIBUTION SERVICES

8. The authority citation for Part 74 continues to read as follows:

Authority: Sec. 4, 303, 48 Stat. 1066, as amended, 1082, as amended; 47 U.S.C. 154, 303, unless otherwise noted. Interpret or apply secs. 301, 303, 307, 48 Stat. 1081, 1082, as amended, 1083, as amended; 47 U.S.C. 301, 303, 307, unless otherwise noted.

9. Section 74.536 is amended by revising the entry for the frequency band 31,000 to 31,300 MHz in the table and adding a new footnote 2 to the table in paragraph (b) as follows:

§ 74.536 Directional antenna required.

* * * * *

(b) * * *

Frequency (MHz)	Category	Maximum beamwidth to 3 db points (included angle in degrees)	Minimum antenna gain (dBi)	Minimum radiation suppression to angle in degrees from centerline of main beam in decibels						
				5 to 10	10 to 15	15 to 20	20 to 30	30 to 100	100 to 140	140 to 180
31,000 to 31,300 [2]	NA	[1] 4.0	38.0							

[1] The minimum front-to-back ratio shall be 38 dBi.
[2] Mobile, except aeronautical mobile, stations need not comply with these standards.

* * * * *

10. Section 74.641 is amended by revising the entry for the frequency band 31,000 to 31,300 MHz in the table and adding a new footnote 2 to the table in paragraph (a)(1) as follows:

§ 74.641 Antenna systems.

(a) * * *

(1) * * *

Frequency (MHz)	Category	Maximum beamwidth to 3 dB points (included angle in degrees)	Minimum antenna gain (dbi)	Minimum radiation suppression to angle in degrees from centerline of main beam in decibels						
				5 to 10	10 to 15	15 to 20	20 to 30	30 to 100	100 to 140	140 to 180
31,000 to 31,300 [2]	NA	[1] 4.0	38.0							

[1] The minimum front-to-back ratio shall be 38 bBi.
[2] Mobile. except aeronautical mobile, stations need not comply with these standards.

* * * * *

PART 78—CABLE TELEVISION RELAY SERVICE CHANGES

11. The authority citation for Part 78 continues to read as follows:

Authority: Sec. 2, 3, 4, 301, 303, 307, 308, 309, 48 Stat. as amended, 1064, 1065, 1066, 1081, 1082, 1083, 1084, 1085; 47 U.S.C. 152, 153, 154, 301, 303, 307, 308, 309, unless otherwise noted.

12. Section 78.105 is amended by revising the entry for the frequency band 31,000 to 31,300 MHz in the table and adding a new footnote 2 to the table in paragraph (a)(1) as follows:

§ 78.105 Antenna systems.

(a) * * *

(1) * * *

Frequency (MHz)	Category	Maximum beamwidth to 3 dB points (included angle in degrees)	Minimum antenna gain (dBi)	Minimum radiation suppression to angle in degrees from centerline of main beam in decibels						
				5 to 10	10 to 15	15 to 20	20 to 30	30 to 100	100 to 140	140 to 180
31,000 to 31,300 [2]	NA		[1] 4.0	38.0						

[1] The mimimum front-to-back ratio shall be 38 dBi.
[2] Mobile, except aeronautical mobile, stations need not comply with these standards.

* * * * *

PART 94—PRIVATE OPERATIONAL-FIXED MICROWAVE SERVICE

13. The authority citation for Part 94 continues to read as follows:

Authority: Sec. 4, 303, 48 Stat. 1066, 1082; 47 U.S.C. 154, 303, unless otherwise noted.

14. Section 94.75 is amended by revising the entry for the frequency band 31,000 to 31,300 MHz in the table and adding a new footnote 8 to the table in paragraph (b) as follows:

§ 94.75 Antenna limitations

* * * * *

(b) * * *

Frequency (MHz)	Category	Maximum beamwidth to 3 dB points (included angle in degrees)	Minimum antenna gain (dBi)	Minimum radiation suppression to angle in degrees from centerline of main beam in decibels						
				5 to 10	10 to 15	15 to 20	20 to 30	30 to 100	100 to 140	140 to 180
31,00 to 31,300 [8]	NA		[7] 4.0	38.0						

[7] The minimum front-to-back ratio shall be 38 dBi.
[8] Mobile, except aeronautical mobile, stations need not comply with these standards.

* * * * *

William J. Tricarico,
Secretary.

[FR Doc. 86-10289 Filed 6-2-86; 8:45 am]
BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 85-333; RM-4986, 5284]

Radio Broadcasting Services; Bedford, NH, et al.

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allocates Channel 243A to Bedford, New Hampshire, at the request of Richard Taylor, and Channel 299A to Hillsborough, New Hampshire, at the request of John Perry. The allotments could provide each community with its first local FM service. With this action, this proceeding is terminated.

EFFECTIVE DATE: July 3, 1986; The window period for filing applications will open on July 7, 1986, and close on August 4, 1986.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 85-333, adopted May 13, 1986, and released May 27, 1986. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW, Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW, Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 is revised to read:

Authority: 47 U.S.C. 154, 303.

2. § 73.202(b) is amended by adding the following:

§ 73.202(b) Table of Allotments.

* * * * *

(b) * * *

City	Channel No.
Bedford, NH	243A
Hillsborough, NH	299A

Charles Schott,
Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86-12328 Filed 6-2-86; 8:45 am]
BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 85-311; RM-5032, 5229]

Radio Broadcasting Services: Karns and Maryville, TN

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document allots FM Channel 226A to Karns, Tennessee, and FM Channel 239A to Maryville, Tennessee, at the request of Piedmont Partnership and Dove, Inc., respectively. The allotments could provide each community with its first FM local service. Channel 239A requires a site restriction of 10.5 kilometers (6.5 miles) northwest of Maryville. With this action, this proceeding is terminated.

DATES: Effective June 30, 1986; The window period for filing applications will open on July 1, 1986, and close on July 30, 1986.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 85-311, adopted May 7, 1986, and released May 23, 1986. The full text of this Commission decision is available for inspection and

copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW, Washington, DC. The complete text of this decision may also be purchased from the Commission copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW, suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read:

Authority: 47 U.S.C. 154, 303.

2. § 73.202(b) is amended by adding the following:

§ 73.202 Table of Allotments

* * * * *

(b) * * *

City	Channel No.
Karns, TN	226A
Maryville, TN	239A

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86-12329 Filed 6-2-86; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 85-318; RM-5096]

Television Broadcasting Services; Richland Center, WI

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document assigns UHF Television Channel 45 to Richland Center, Wisconsin, as that community's first local television broadcasting service at the request of Kaul-Tronics, Inc. The assignment requires a site restriction of 2.7 miles northeast of the community. With this action, this proceeding is terminated.

EFFECTIVE DATE: June 30, 1986.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order, MM Docket No. 85-318, adopted May 7, 1986, and released May 23, 1986. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street NW., Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Television broadcasting.

PART 73—(AMENDED)

1. The authority citation for Part 73 continues to read:

Authority: 47 U.S.C. 154, 303.

2. Section 73.606(b) is amended by adding the following:

80§ 73.606 Table of assignments.

* * * * *

(b) * * *

City: Richland Center, Wisconsin; *Channel No.* 45+.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 86-12331 Filed 6-2-86; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF DEFENSE

Department of the Navy

48 CFR Parts 5242 and 5252

Department of the Navy Federal Acquisition Regulations; Policy Concerning Navy Requests for Refunds

AGENCY: Department of the Navy.

ACTION: Final rule.

SUMMARY: The Department of the Navy is establishing Chapter 52 and adding Subpart 5242.90, *Refunds Requirements (Spares and Support Equipment)*, Section 5242.9000, Requests for Refunds, and Subpart 5252.2, *Texts of Provisions and Clauses*, Section 5252.242-9000, Refunds, to set forth Navy policy on refunds to the Government. Existing policy included in the Federal Acqusition Regulation (FAR) and the Defense Federal Acquisition Regualtion Supplement (DFARS) only pertains to the solicitation of voluntary refunds for overpriced items. This new rule sets forth a Navy policy with regard to requesting and obtaining contractually prescribed refunds from contractors for spare parts or items of support equipment when it is determined that the negotiated price of such parts or items significantly exceeds the intrinsic value of the parts or items.

EFFECTIVE DATE: 28 April 1986.

FOR FURTHER INFORMATION CONTACT: Mr. Sidney Tronic, Office of the Assistant Secretary of the Navy (Shipbuilding & Logistics), Contracts and Business Management (CBM-BPC), Washington, DC 20360-5000, Telephone: (202) 692-3553/8/9.

SUPPLEMENTARY INFORMATION:

1. Background

The Navy guidance and clause at Subpart 5242.90, Section 5242.9000 and Subpart 5252.2, Section 5252.242-9000 allows the Navy to obtain a refund or a negotiated price adjustment whenever the Navy determines a price paid for a spare part or item of support equipment significantly exceeds the intrinsic value of the part or item.

Proposed rulemaking was published on December 4, 1985, at 50 FR 49819 and invited comments for 30 days ending January 3, 1986. Comments were received from seven sources, including individuals, companies, and industrial associations. The following summarizes significant comments, suggestions, and actions taken.

Inconsistent with Existing Policy

It was suggested that the Navy's refund policy is inconsistent with the intentions of the Secretary of Defense to establish a uniform refund policy for all of DOD. It was also suggested that the Navy's refund policy is prohibited by the FAR and the DFARS. The Navy does not agree. The FAR and the DFARS do not prohibit a mandatory refund policy. Rather, they are silent on this matter. The deviation which the Navy obtained from the DAR Council authorizes use of a Navy unique clause.

No Time Limit

Concern was expressed that the Navy's proposed clause did not specify a time limit for the Navy to obtain a refund. The clause has been clarified to indicate that the Navy can request a refund at any time either before or after final payment under the contract.

Inconsistent With General Contracting Principles

Concern was expressed that the Navy's proposed clause was inconsistent with general contracting principles which would not permit one party to a contract to unilaterally reopen the agreement and then either annul the agreement or renegotiate the price on the basis of information which might not have been available at the time of the original negotiations. The Navy does not agree that its clause is inconsistent with general contracting principles. The parties to a binding contract may agree to include a clause which provides for a contract price adjustment in certain circumstances, including, for example, the obtaining by one party of additional

information concerning the reasonableness of the contract price. There are many contracts which include price adjustment provisions.

Use for More Than Spare Parts

Concern was expressed that the Navy's proposed policy and clause were worded such that they could be interpreted as applying to more than spare and similar parts. The policy and the clause have been reworded to clarify that they apply only to refunds for spare parts and items of support equipment.

Applicability to Competitively Obtained Prices

It was suggested that the Navy's proposed clause should not be required in contracts awarded as a result of competition. The policy and the clause have been changed so that the clause is not required with respect to spare parts and items of support equipment whose prices are established through sealed bidding or competitive small purchase procedures.

2. Statutory and Regulatory Requirements

This rule will not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 et seq.) and is not a "major" rule pursuant to E.O. 12291. The Paperwork Reduction Act (44 U.S.C. 3501 et seq.) does not apply to this rule because it does not impose any additional reporting requirements on the public.

List of Subjects in 48 CFR Parts 5242 and 5252

Government procurement.

For the reasons set out in the preamble, Chapter 52 of Title 48 of the Code of Federal Regulations is established and Parts 5242 and 5252 are added to read as follows.

CHAPTER 52—DEPARTMENT OF THE NAVY ACQUISITION REGULATIONS

PART 5242—CONTRACT ADMINISTRATION

Authority: 5 U.S.C. 301, 10 U.S.C. 2202, DOD Directive 5000.35.

Subpart 5242.90—Refunds Requirements (Spares and Support Equipment)

5242.9000 Request for refunds.

(a) *Policy.* This subpart establishes uniform policy and procedures on requesting refunds and ensuring fair and reasonable prices for spare parts or items of support equipment. Contracting activities shall request a refund whenever the contract price of any spare part or item of support equipment significantly exceeds the item's intrinsic value after considering the impact of specified delivery terms and quantity. The intrinsic value of an item is the price an individual would expect to pay based upon the cost to manufacture, using standard labor costs, material costs, shop cost and reasonable markup for overhead and profit. The following circumstances are examples which may establish a basis for a refund or pricing adjustment:

(1) A technical or engineering analysis, such as that done by PRICE FIGHTER, results in a determination that the intrinsic value is significantly lower than the historical pricing structure.

(2) The price paid for an item bought competitively in similar quantity and circumstances (e.g., urgency, delivery terms) is significantly less than the former sole source price.

(3) Prices paid to the actual manufacturer of an item indicate the amount previously charged by the prime contractor for the item significantly exceeded the value added by the prime contractor in providing the item.

(4) Postaward price reviews which indicate an increase in recent contract price which causes the price to exceed significantly the intrinsic value of the part.

(5) Postaward audit reports which identify over-charges.

(b) *Solicitation Provisions.* The contracting officer shall insert the clause at 5252.242-9000 in solicitations, Basic Ordering Agreements, and contracts (as defined in FAR 2.101) which contain or may contain requirements for spare parts or items of support equipment, except those contracts awarded as a result of competitive small purchase procedures. Heads of contracting activities are delegated, without power of redelegation, authority to establish monetary thresholds below which refunds will not be requested.

PART 5252—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

Authority: 5 U.S.C. 301, 10 U.S.C. 2202, DOD Directive 5000.35.

Subpart 5252.2—Texts of Provisions and Clauses

5252.242-9000 Refunds.

As prescribed in 5242.9000 insert the following clause:

Refunds (Spares and Support Equipment) (April 86)

(a) In the event that the negotiated price of a spare part or item of support equipment under this contract exceeds its intrinsic value, the contractor agrees to refund the difference. The intrinsic value of an item is defined as the price an individual would expect to pay based upon the cost to manufacture, using standard labor costs, material costs, shop cost and reasonable markup for overhead and profit.

(b) At any time before or after final payment under this contract, the contracting officer may notify the contractor of any negotiated price of an item described above that, based on all information available to the contracting officer at the time of the notice, exceeds the intrinsic value of the item.

(c) The contractor shall enter into good faith negotiations for the downward repricing of the item. All information available to the Navy, whether or not available at the time the original contract price was negotiated and any additional information, including cost data, supplied by the Contractor, shall be considered in determining the amount of any refund.

(d) Refunds under an open contract shall be made by a contract modification. Refunds under closed contracts shall be made by means of a check payable to the office designated for contract administration.

(e) If agreement on a downward repricing of the item cannot be reached, and the Navy's return of the new or unused item to the contractor is practical, the Navy may elect to return the item to the contractor. Upon return of the item to its original point of government acceptance, the contractor shall refund in full the price paid. If no agreement concerning downward repricing is reached, and return of the item by the Navy is impractical the Contracting Officer may, with approval of the Head of the Contracting Activity, determine a reasonable refund, subject to contractor appeal as provided in the Disputes clause.

(End of Clause)

Dated: May 28, 1986.

William F. Roos, Jr.,

Lt, JAGC, U.S. Naval Reserve Federal Register Liaison Officer.

[FR Doc. 86-12395 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-AE-M

INTERSTATE COMMERCE COMMISSION

49 CFR Part 1241

[Ex Parte No. 460]

Certification of Railroad Annual Report R-1 by Independent Accountant

AGENCY: Interstate Commerce Commission.

ACTION: Clarification of Final Rules.

SUMMARY: On October 16, 1985 (50 FR 41899) the Commission published final rules which require Class I railroads to submit a report from an independent public accountant stating that specified data in the R-1 annual report have been examined, using agreed-upon procedures, and found to be in compliance with the Uniform System of Accounts for Railroad Companies (49 CFR Part 1201).

Subsequent to the issuance of the Final Rules, Association of American Railroads (AAR) requested that the Commission clarify the audit requirements of Schedules 200 and 210; affirm that the data audited by the independent accountants will be accorded the same procedural treatment and presumption of credibility presently accorded to the R-1 data; publish the proposed auditing procedures for comment prior to their adoption; and strike that portion of the Final Rules which imposes additional audit requirements without prior notice.

The Commission has clarified the audit requirements and reaffirms the procedural treatment and credibility of the R-1 data as requested in the AAR petition. It also has aligned the audit requirements with those originally proposed.

DATE: Effective for the R-1 annual reports for the year 1986, which are due to be filed by March 31, 1987.

FOR FURTHER INFORMATION CONTACT: William F. Moss III (202) 275-7510.

SUPPLEMENTARY INFORMATION: Additional information is contained in the Commission's decision. To purchase a copy of the full decision, write to T. S. InfoSystems, Inc., Room 2229, Interstate Commerce Commission Building, Washington, DC 20423, or call 289-4357 (DC Metropolitan area) or toll free (800) 424-5403.

This action will not significantly affect either the quality of the human environment or energy conservation. This rule will not have a significant economic impact on a substantial number of small entities.

List of Subjects in 49 CFR Part 1241

Railroads; Reporting and recordkeeping requirements.

Authority: 49 U.S.C. 11145 and 5 U.S.C. 553.

Decided: May 22, 1986.

By the Commission, Chairman Gradison, Vice Chairman Simmons, Commissioners Sterrett, Andre, and Lamboley. Commissioner Lamboley commented with a separate expression.

James H. Bayne,

Secretary.

[FR Doc. 86-12362 Filed 6-2-86; 8:45 am]

BILLING CODE 7035-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 661

[Docket No. 60477-6077]

Ocean Salmon Fisheries off the Coasts of Washington, Oregon, and California

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of reopening of fishery.

SUMMARY: The Secretary of Commerce (Secretary) announces the reopening for two days of the non-Indian commercial salmon fishery for all species except coho from the U.S.-Canadian border to Cape Falcon, Oregon. The fishery was closed on May 19, 1986, when it was projected that the harvest quota had been reached. Subsequent evaluation of landings indicated that the actual catch had been overestimated, and the fishery was reopened from May 24 through May 27, 1986. Further evaluation of landings indicates nearly 6,000 fish remain to be harvested in the troll quota. This reopening is calculated to maximize ocean harvest of chinook salmon without exceeding the established quota.

DATES: Reopening of the fishery conservation zone (FCZ) from the U.S.-Canada border to Cape Falcon, Oregon, to non-Indian commercial salmon fishing is effective at 0001 hours Pacific Daylight Time (PDT) May 30, 1986, until 2400 hours PDT May 31, 1986. Comments on this notice will be received until June 18, 1986.

ADDRESS: Comments may be mailed to the Director, Northwest Region, NMFS, BIN C15700, 7600 Sand Point Way, NE., Seattle, WA 98115-0070. Information relevant to this notice has been compiled in aggregate form and is available for public review during business hours at the same address.

FOR FURTHER INFORMATION CONTACT: Rolland A. Schmitten (Regional Director), 206-526-6150.

SUPPLEMENTARY INFORMATION: Regulations governing the ocean salmon fisheries at 50 CFR Part 661 specify at § 661.21(a)(2) that "If a fishery is closed under a quota before the end of a scheduled season based on an overestimate of actual catch, the Secretary may reopen that fishery for all or part of the remaining original season by publication of a notice in the **Federal Register** under § 661.23 in order to allow the quota to be met so long as the additional period is no less than 24 hours."

The commercial fishery from the U.S.-Canada border to Cape Falcon, Oregon, was closed at midnight, May 19, 1986 (51 FR 18795; May 22, 1986) when it was projected that the harvest quota of 33,700 chinook salmon had been caught. A subsequent evaluation of landings indicated that the original projection was based on an overestimate of actual catch, with approximately 6,900 fish remaining in the quota. Thus, the fishery was reopened for four days, from May 24 through May 27, 1986 (51 FR 19350, May 29, 1986). However, hazardous fishing conditions due to inclement weather prevented full harvest of the quota. Current evaluation of landings indicates nearly 6,000 fish remain in the quota. The Secretary therefore issues this notice to reopen the non-Indian commercial fishery in the FCZ from the U.S.-Canada border to Cape Falcon, Oregon, for two days, from 0001 hours PDT May 30, 1986, until 2400 hours PDT May 31, 1986.

The Regional Director consulted with the Directors of the Washington Department of Fisheries (WDF) and the Oregon Department of Fish and Wildlife (ODFW) regarding this reopening. The Directors of WDF and ODFW confirmed that Washington and Oregon will reopen the commercial fishery in State waters adjacent to this area of the FCZ during the same time period.

Other Matters

This action is taken under § 661.21 and 661.23 and is in compliance with Executive Order 12291.

List of Subjects in 50 CFR Part 661

Fisheries, Fishing, Indians.

Dated: May 29, 1986.

Carmen J. Blondin,

Deputy Assistant Administrator For Fisheries Resource Management, National Marine Fisheries Service.

[FR Doc. 86-12435 Filed 5-29-86; 4:45 pm]

BILLING CODE 3510-22-M

50 CFR Part 671

[Docket No. 50950-5182]

Tanner Crab off Alaska

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Notice of season closure.

SUMMARY: The Director, Alaska Region, NMFS (Regional Director), has determined that the *Chinoecetes opilio* Tanner crab fishery in the Pribilof Subdistrict of the Bering Sea District of Registration Area J (Westward) must be closed in order to protect all Tanner crab stocks. The Secretary of Commerce therefore issues this notice closing fishing for all Tanner crabs by vessels of the United States in the Pribilof subdistrict effective June 1, 1986. This action is intended as a management measure to conserve Tanner crab stocks.

DATES: This notice is effective at noon, Alaska Daylight Time (ADT), June 1, 1986. Public comments on this notice of closure are invited until June 18, 1986.

ADDRESSES: Comments should be sent to Robert W. McVey, Director, Alaska Region, National Marine Fisheries Service, P.O. Box 1668, Juneau, AK 99802. During the 15-day comment period, the data on which this notice is based will be available for public inspection during business hours (8:00 am. to 4:30 p.m., AST, weekdays) at the NMFS Alaska Regional Office, Federal Building, Room 453, 709 West Ninth Street, Juneau, Alaska.

FOR FURTHER INFORMATION CONTACT: Raymond E. Baglin (Fishery Management Biologist, NMFS), 907-586-7230.

SUPPLEMENTARY INFORMATION: The Fishery Management Plan for the Commercial Tanner Crab Fishery off the Coast of Alaska (FMP), which governs this fishery in the fishery conservation zone under the Magnuson Fishery Conservation and Management Act (Magnuson Act), provides for inseason adjustments of area openings and closures. Implementing regulations at § 671.27(b) specify that notices of these adjustments will be issued by the Secretary of Commerce under criteria set out in that section.

Section 671.26(f) establishes six districts within Registration Area J to independently manage individual Tanner crab stocks. One of these districts is the Bering Sea District, which is further divided into three subdistricts enabling management of localized Tanner crab stocks. The regularly scheduled 1986 fishing season for *C. opilio* in the Pribilof Subdistrict began on January 15, 1986 (50 FR 47549, November 19, 1985).

Reasons for this closure follow:

The optimum yield range for the entire Bering Sea District fishery for *C. opilio* Tanner crabs is 20-130 million pounds. The 1985 NMFS trawl survey indicated that 57 million pounds of male *C. opilio*, 4 inches and larger in carapace width, would be available at a desired exploitation rate of 0.58. The survey predicated that about 28 million pounds of this total would be available from the Pribilof Subdistrict.

Fishery performance, however, has indicated that a larger population of crab than was anticipated before the season was available and the catch has exceeded the survey prediction while exhibiting relatively stable catch per unit of effort (CPUE). As of May 18, 1986, approximately 70 vessels have delivered about 44 million pounds of *C. opilio* Tanner crab. Analysis of CPUE data indicates that a harvest of 50 million pounds of *C. opilio* will be achieved by noon June 1, 1986. Fishery performance has been closely monitored throughout the entire fishery. The CPUE averaged about 220 crabs per pot during January. The overall CPUE remained steady during February, March, and April with an average of about 150 crabs per pot. During May a rapid downward trend in CPUE occurred with the catch declining from about 169 to 92 crabs per pot. This indicates that the fishery has begun to deplete the remaining *C. opilio* stock and a fishery closure is necessary to conserve the reproductive capacity of the remaining stock. Due to low CPUE, the fishing fleet has already started to move out of the Pribilof Subdistrict and into the Northern Subdistrict.

In light of this information, the Regional Director has determined that the condition of the *C. opilio* Tanner crab stocks in the Pribilof Subdistrict is substantially different from the condition anticipated at the beginning of the fishing year, and that this difference reasonably supports the need to protect the Tanner crab stocks. The Pribilof Subdistrict, as defined in § 671.26(f) (1) (vi) (B), is closed by this notice until noon, ADT, August 1, 1986, at which time the closure of the entire Bering Sea District prescribed in Table 1 of § 671.21(a) will begin.

This closure will become effective after this notice is filed for public inspection with the Office of the Federal Register and the closure is publicized for 48 hours through procedures of the Alaska Department of Fish and Game. Public comments on this notice of closure may be submitted to the Regional Director at the address above. If comments are received, the necessity of this closure will be reconsidered and a subsequent notice will be published in the **Federal Register**, either confirming this notice's continued effect, modifying it, or rescinding it.

Other Matters

Tanner crab stocks in the the Pribilof Subdistrict of Registration Area J (Westward) will be subject to damage by overfishing unless this closure takes effect promply. NOAA therefore finds for good cause that advance opportunity for public comment on this notice is contrary to the public interest and that no delay should occur in its effective date.

This action is taken under 50 CFR Part 671 and complies with Executive Order 12291.

List of Subjects in 50 CFR Part 671

Fisheries, Reporting and recordkeeping requirements.

Authority: 16 U.S.C 1801 et seq.

Dated: May 29, 1986.

Carmen J. Blondin,

Deputy Assistant Administrator For Fisheries Resource Management, National Marine Fisheries Service.

[FR Doc. 86-12434 Filed 5-29-86; 4:47 pm]

BILLING CODE 3510-22-M

Proposed Rules

Federal Register
Vol. 51, No. 106
Tuesday, June 3, 1986

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Agricultural Marketing Service

7 CFR Part 1065

Milk in the Nebraska-Western Iowa Marketing Area; Notice of Proposed Suspension of Certain Provisions of the Order

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Proposed suspension of rule.

SUMMARY: This notice invites public comments on a proposal to suspend for the months of June through August 1986 the requirement that a cooperative association deliver 51 percent or more of the producer milk of members of the association to pool distributing plants of other handlers in order to qualify a supply plant operated by the cooperative association that represents producers who supply milk for the market. The association claims that this action is necessary to assure that its member dairy farmers who have regularly supplied the market's fluid needs will continue to share in the market's fluid milk sales.

DATE: Comments are due on or before 7 days after publication in the **Federal Register**.

ADDRESS: Comments (two copies) should be filed with the Dairy Division, Room 2968, South Building; U.S. Department of Agriculture, Washington, DC 20250.

FOR FURTHER INFORMATION CONTACT: Constance M. Brenner, Marketing Specialist, Dairy Division, Agriculture Marketing Service, U.S. Department of Agriculture, Washington, DC 20250, (202) 447-7311.

SUPPLEMENTARY INFORMATION: The Administrator of the Agriculture Marketing Service has certified that this proposed action would not have a significant economic impact on a substantial number of small entities. Such action would lessen the regulatory impact of the order on certain milk handlers and would tend to ensure that dairy farmers would continue to have their milk pooled and priced under the order and thereby receive the benefits that accue from such pricing.

Notice is hereby given that, pursuant to the provisions of the Agriculture Marketing Agreement Act of 1937, as amended (7 U.S.C. 601-674), the suspension of the following provisions of the order regulating the handling of milk in the Nebraska-Western Iowa marketing area is being considered for the months of June through August 1986:

In § 1065.7(c), the words "51 percent or more of the".

All persons who want to send written data, views or arguments about the proposed suspension should send two copies of them to the Dairy Division, Agricultural Marketing Service, Room 2968, South Building, U.S. Department of Agriculture, Washington, DC 20250, by the 7th day after publication of this notice in the **Federal Register**. The period for filing comments is limited to 7 days because a longer would not provide the time needed to complete the required procedures and include June 1986 in the suspension period.

The comments that are sent will be made available for public inspection in the Diary Division during normal business hours (7 CFR 1.27(b)).

Statement of Consideration

The proposed suspension would remove for the months of June through August 1986 the requirement that a cooperative association deliver 51 percent or more of the producer milk of members of the association to pool distributing plants of other handlers in order to qualify a supply plant operated by the cooperative association for pooling. The suspension was requested by Mid-America Dairymen, Inc. (Mid-Am), a cooperative association that represents a large number of the market's producers.

The cooperative states that the proposed suspension is needed because of increased production by the cooperative's members, as well as for the market as a whole, that greatly exceeds increased Class I sales. For the months of January through April 1986, Mid-Am production pooled on the Nebraska-Western Iowa order was 10.1 percent higher than for the same period of 1986, while Class I sales increased only 0.2 percent.

With the decrease in Class I sales that will accompany the closing of schools for the summer, Mid-Am states that the percentage of the cooperative's producer milk shipped to Nebraska-Western Iowa pool distributing plants is likely to fall below 51 percent. As alternatives to depooling some milk of its member producers, the cooperative would have to attempt to pool Nebraska-Western Iowa producer milk on another Federal order or ship milk to distributing plants where the milk would be received, loaded back into the truck and shipped to a manufacturing plant. Either alternative would require the cooperative to move milk in an uneconomic and inefficient manner solely to maintain the pool status of producers who historically have supplied the fluid needs of the Nebraska-Western Iowa marketing area.

List of Subjects in 7 CFR Part 1065

Milk marketing orders, Milk, Dairy products.

The authority citation for 7 CFR Part 1065 continues to read as follows:

Authority: Secs. 1-19, 48 Stat. 31, as amended; 7 U.S.C. 601-674.

Signed at Washington, DC on: May 28, 1986.

William T. Manley,

Deputy Administrator, Marketing Programs.

[FR Doc. 86-12366 Filed 6-2-86; 8:45 am]
BILLING CODE 3410-02-M

Animal and Plant Health Inspection Service

9 CFR Part 151

[Docket No. 86-001]

Recognized Breeds and Books of Record

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend the "Recognition of Breeds and Books of Record of Purebred Animals" regulations by adding the Irish Angus Herd Book, maintained by the Irish Angus Cattle Society Ltd., to the list of "recognized breeds and books of record" for Aberdeen-Angus cattle. It has been determined that the Irish Angus Herd Book qualifies for such listing, thereby providing for duty-free

entry into the United States of cattle which are registered in the book.

DATE: Written comments must be received on or before August 4, 1986.

ADDRESS: Written comments concerning this proposed rule should be submitted to Thomas O. Gessel, Director, Regulatory Coordination Staff, APHIS, USDA, Room 728, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782. Comments should state that they are in response to Docket No. 86-001. Written comments received may be inspected at Room 728 of the Federal Building between 8 a.m. and 4:30 p.m., Monday through Friday, except holidays.

FOR FURTHER INFORMATION CONTACT: Dr. Robert E. Wagner, Regulatory Communications and Compliance Policy Staff, VS, APHIS, USDA, Room 827, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, 301-436-8565.

SUPPLEMENTARY INFORMATION:

Background

Item 100.01 in Part 1, Schedule 1, of 19 U.S.C. 1202 (the Tariff Act of 1930, as amended) provides, in part, that animals (except for certain foxes) certified to the collector of customs by the Department of Agriculture as being pure bred of a recognized breed and duly registered in a book of record recognized by the Secretary of Agriculture for that breed, may enter the United States free of duty if imported for breeding purposes. Implementing regulations, captioned "Recognition of Breeds and Books of Record of Purebred Animals" (referred to below as the regulations), are set forth in 9 CFR Part 151.

In accordance with § 151.2 of the regulations, Veterinary Services issues certificates of pure breeding for certain animals. To be eligible for a certificate, an animal must be "purebred of a recognized breed and have been registered in good faith in a book of record listed in § 151.9(a) [of the regulations] and must not have been registered on inspection without regard to purity of breeding." The regulations contain lists of "recognized breeds and books of record" for cattle, horses, asses, sheep, goats, swine, dogs, and cats.

Under the regulations, purebred cattle are those which are the progeny of known and registered ancestors of the same recognized breed and for which at least three generations of ancestry can be traced. A "book of record" is defined in the regulations as: "[a] printed book or an approved microfilm record sponsored by a registry association and containing breeding data relative to a large number of registered purebred animals used as a basis for the issuance of pedigree certificates." The regulations also provide that a book of record for a breed of animal must be examined and approved by Veterinary Services before the breed and book of record are eligible to be added to the list contained in the regulations.

The custodian of the Irish Angus Herd Book, a book of record for Aberdeen-Angus cattle issued by the Irish Angus Cattle Societ Ltd., has submitted to Veterinary Services a complete copy of the book of record with a copy of all rules and forms affecting the registration of the animals in the book of record. A representative of Veterinary Services has reviewed the material submitted and has determined that this book of record meets the requirements of the regulations for addition to the list of "recognized breeds and books of record."

Therefore, this document proposes to amend the list of "recognized breeds and books of record" in § 151.9(a) of the regulations by adding as an additinal book of record for the Aberdeen-Angus breed, the "Irish Angus Herd Book," issued by the Irish Angus Cattle Society Ltd., John L. Murphy, Secretary, Agriculture House, Kildare Street, Dublin 2, Ireland.

Executive Order 12291 and Regulatory Flexibility act

This action has been reviewed in conformance with Executive Order 12291 and has been determined to be not a "major rule." The Department has determined that this action would not have a significant effect on the economy; would not cause a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; and would have no significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

For this action, the Office of Management and Budget has waived its review process required by Executive Order 12291.

If the proposal is adopted as a final rule, Aberdeen-Angus cattle listed in the Irish Angus Herd Book will be eligible for duty-free importation into the United States. It is anticipated that the number of these Aberdeen-Angus cattle imported into the United States annually would be less than one percent of the total number of cattle imported into the United States annually.

Under the circumstances explained above, the Administrator of the Animal and Plant Health Inspection Service has determined that this action would not have a significant economic impact on a substantial number of small entities.

Executive Order 12372

This program/activity is listed in the Catalog of Federal Domestic Assistance under No. 10.025 and is subject to the provisions of Executive Order 12372 which requires intergovernmental consultation with State and local officials. (See 7 CFR Part 3015, Subpart V).

List of Subjects in 9 CFR Part 151

Animals, Animal pedigree, Imports, Purebred animals.

PART 151—RECOGNITION OF BREEDS AND BOOKS OF RECORD OF PUREBRED ANIMALS

Accordingly, 9 CFR Part 151 would be amended as follows:

1. The authority citation for Part 151 would be revised to read as set forth below and the authority citations following all the sections in Part 151 would be removed:

Authority: 19 U.S.C. 1202; 7 CFR 2.17, 2.51, and 371.2(d).

2. In § 151.9, the chart in paragraph (a) would be amended by adding the following after Code 1112 under the heading "Cattle":

§ 151.9 Recognized breeds and books of record.

* * * * *

(a) * * *

CATTLE

Code	Name of breed	Book of record	By whom published
1116	Aberdeen-Angus	Irish Angus Herd Book	Irish Angus Cattle Society Ltd., John L. Murphy, Secretary, Agriculture House, Kildare Street, Dublin 2, Ireland.

Done at Washington, DC, this 28th day of May 1986.

Billy G. Johsnon,

Acting Deputy Administrator, Veterinary Services.

[FR Doc. 86-12424 Filed 6-2-86; 8:45 am]

BILLING CODE 3410-34-M

NATIONAL CREDIT UNION ADMINISTRATION

12 CFR Part 709

Division of Assets, Liabilitities and Capital; Proposed Deletion

AGENCY: National Credit Union Administration.

ACTION: Proposed deletion of existing regulation.

SUMMARY: The deletion of Part 709—Division of Assets, Liabilities and Capital—is proposed because the regulation has been rarely used and is no longer needed. Special situations can be handled on a case-by-case basis without the regulation.

DATE: Comments must be received on or before August 6, 1986.

ADDRESS: Send comments to Rosemary Brady, Secretary, National Credit Union Administration Board, 1776 G Street, NW., Washington, DC 20456.

FOR FURTHER INFORMATION CONTACT: D. Michael Riley, Director, Office of Examination and Insurance, at the above address, or telephone: (202) 357-1065.

SUPPLEMENTARY INFORMATION: NCUA requests comment on its proposal to delete Part 709 of the NCUA Rules and Regulations. Part 709—Division of Assets, Liabilities and Capital—contains provisions and procedures that enable members of a Federal credit union, who are a separately identifiable group, to undertake an equitable division of their assets, liabilities and capital, and charter a new Federal credit union. The most recent update of Part 709 was in 1973. Significant economic and policy changes have occurred since the regulation was modified. Over the past few years, there have been few, if any, "spin offs" using Part 709 of the Rules and Regulations. Accordingly, there does not appear to be a need to retain this regulation. In addition, a number of requirements contained in Part 709 are duplicated in other sections of the Regulations, Bylaws, and chartering and insurance policies. These other provisions provide adequate flexibility for special cases to be resolved when, and if, they arise.

Regulatory Procedures

The NCUA Board hereby certifies that the proposed deletion, if adopted, will not have a significant economic impact on a substantial number of small credit unions. The elimination of the regulation will reduce regulatory burden and will not create any negative impact on credit unions.

Paperwork Reduction Act

The proposed deletion will not increase collection requirements under the Paperwork Reduction Act. Therefore, the approval of the Office of Management and Budget is not required.

List of Subjects in 12 CFR Part 709

Division of assets, Liabilities and capital, Credit unions.

By the National Credit Union Administration Board on the 21st day of May 1986.

Rosemary Brady,

Secretary of the Board.

PART 709—[REMOVED]

Accordingly, NCUA proposes to remove Part 709 from the Regulations.

Authority: 12 U.S.C. 1766, 1789.]

[FR Doc. 86-12417 Filed 6-2-86; 8:45 am]

BILLING CODE 7535-01-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 86-NM-124-AD]

Airworthiness Directives; Boeing Model 737-300 Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This notice proposes to adopt an airworthiness directive (AD) that would require inspection for proper clearance between the number two engine fuel feed tube and adjacent strut fairing fasteners on certain Boeing Model 737-300 airplanes, and adjustment or replacement, if necessary. This action is prompted by a report of a fuel leak on one airplane, resulting from chafing between the fuel tube and fasteners. This condition, if not corrected, could result in a strut fire.

DATES: Comments must be received on or before July 25, 1986.

ADDRESSES: Send comments on the proposal in duplicate to the Federal Aviation Administration, Northwest Mountain Region, Office of the Regional Counsel (Attn: ANM-103), Attention: Airworthiness Rules Docket No. 86-NM-124-AD, 17900 Pacific Highway South, C-68966, Seattle, Washington 98168. The applicable service information may be obtained from the Boeing Commercial Airplane Company, P.O. Box 3707, Seattle, Washington 98124. This information may be examined at the FAA, Northwest Mountain Region, 17900 Pacific Highway South, Seattle, Washington, or the Seattle Aircraft Certification Office, 9010 East Marginal Way South, Seattle, Washington.

FOR FURTHER INFORMATION CONTACT: Mr. Stewart R. Miller, Aerospace Engineer, Propulsion Branch, ANM-140S; telephone (206) 431-2969. Mailing address: FAA, Northwest Mountain Region, 17900 Pacfic Highway South, C-68966, Seattle, Washington 98168.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submittting such written data, views, or arguments as they may desire. Communications should identify the regulatory docket number and be sumitted in duplicate to the address specified above. All communications received on or before the closing date for comments specified above will be considered by the Administrator before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Availability of NPRM

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the FAA, Northwest Mountain Region, Office of the Regional Counsel, Attention: Airworthiness Rules Docket No. 86-NM-124-AD, 17900 Pacific Highway South, C-68966, Seattle, Washington 98168.

Discussion

An operator of a Boeing Model 737-300 reported that, during a walk around inspection, fuel was noted to be dripping from the number two engine strut aft drain. Subsequent investigation revealed the fuel feed tube assembly had chafed through due to contact with adjacent strut fasteners.

An examination, by the manufacturer, of production line airplanes revealed several which did not meet the minumum clearance requirements of appropriate drawings.

Boeing issued Alert Service Bulletin 737-28A1062 on February 21, 1986, which describes an inspection for fuel feed tube assembly clearance and, if necessary, maintenance action to correct the clearance. This was followed by Revision 1 on April 11, 1986, which makes no substantive change from the original. Parts kits (one kit per airplane) became available in February and are now available in sufficient quantity for expected need.

Since a situation exists where chafing of the fuel feed tube assembly could contribute to a fire hazard resulting from a fuel leak in the strut, an AD is proposed that would require inspection of the number two engine fuel feed tube for proper clearance and correction of any unsafe condition found in accordance with Boeing Alert Service Bulletin 737-28A1062, Revision 1, dated April 11, 1986, or later FAA-approved revision.

It is estimated that 60 airplanes of U.S. registry would require inspection, which would require one manhour per airplane to accomplish. It is estimated that 30 airplanes of U.S. registry would require modification, which would require 5 manhours per airplane to accomplish. At an estimated labor cost of $40 per manhour, the impact of this AD on U.S. operators is estimated to be $8,400.

For the reasons discussed above, the FAA has determined that this document (1) involves a proposed regulation which is not major under Executive Order 12291 and (2) is not a significant rule pursuant to the Department of Transportation Regulatory Policies and Procedures (44 FR 11034; February 26, 1979), and it is certified under the criteria of the Regulatory Flexibility Act that this proposed rule, if promulgated, will not have a significant economic impact on a substantial number of small entities because few, if any, Boeing Model 737-300 airplanes are operated by small entities. A copy of a draft regulatory evaluation prepared for this action is contained in the regulatory docket.

List of Subjects in 14 CFR Part 39

Aviation safety, Aircraft.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend § 39.19 of Part 39 of the Federal Aviation Regulations as follows:

1. The authority citation of Part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g) (Revised Pub. L. 97-449, January 12, 1983); and 14 CFR 11.89.

2. By adding the following new airworthiness directive:

Boeing: Applies to the Model 737-300 series airplanes specified in Boeing Alert Service Bulletin, 737-28A1062, Revision 1, dated April 11, 1986, certificated in any category. To minimize the fire hazard associated with a fuel leak due to the fuel feed tube assembly chafing against strut fasteners, accomplish the following within 3 months after the effective date of this AD, unless previously accomplished:

A. Inspect and, if necessary, adjust fuel feed tube assembly clearance and replace chafed tubes in accordance with Boeing Service Bulletin 737-28A1062, Revision 1, dated April 11, 1986, or later FAA-approved revision.

B. An alternate means of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Seattle Aircraft Certification Office, FAA, Northwest Mountain Region.

C. Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate airplanes to a base for the accomplishment of inspections and/or modifications required by this AD.

All persons affected by this proposal who have not already received copies of the manufacturer's Service Bulletin may obtain copies upon request to the Boeing Commercial Airplane Company, P.O. Box 3707, Seattle, Washington 98124-2207. This document may be examined at the FAA, Northwest Mountain Region, 17900 Pacific Highway South, Seattle, Washington, or the Seattle Aircraft Certification Office, 9010 East Marginal Way South, Seattle, Washington.

Issued in Seattle, Washington, on May 27, 1986.

David E. Jones,

Acting Director, Northwest Mountain Region.

[FR Doc. 86-12322 Filed 6-2-86; 8:45 am]

BILLING CODE 4910-13-M

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14 CFR Part 39

[Docket No. 86-NM-125-AD]

Airworthiness Directives; Boeing Model 747-100SR Series Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of Proposed Rulemaking (NPRM).

SUMMARY: This notice proposes to adopt an airworthiness directive (AD) which would require structural inspections and repairs or replacements, as necessary, on certain high time Boeing Model 747-100SR series airplane fuselage and nacelle struts are approaching the manufacturer's original objective fatigue design life. This AD would add the Boeing Model 747-100SR series airplanes to the "Supplemental Structural Inspection Program for Large Transport Category Airplanes" and would define structural maintenance requirements for certain identified structural components.

DATES: Comments must be received on or before July 25, 1986.

ADDRESSES: Send comments on the proposal in duplicate to the Federal Aviation Administration, Northwest Mountain Region, Office of the Regional Counsel (Attn: ANM-103), Attention: Airworthiness Rules Docket No. 86-NM-125-AD, 17900 Pacific Highway South, C-68966, Seattle, Washington 98168. The applicable service information may be obtained from the Boeing Commercial Airplane Company, P.O. Box 3707, Seattle, Washington 98124. This information may be examined at the FAA, Northwest Mountain Region, 17900 Pacific Highway South, Seattle, Washington, or the Seattle Aircraft Certification Office, 9010 East Marginal Way South, Seattle, Washington.

FOR FURTHER INFORMATION CONTACT: Mr. Owen E. Schrader, Airframe Branch, ANM-120S; telephone (206) 431-2923. Mailing address: FAA, Northwest Mountain Region, 17900 Pacific Highway South, C-68966, Seattle, Washington 98168.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the

proposed rule by submitting such written data, views, or arguments as they may desire. Communications should identify the regulatory docket number and be submitted in duplicate to the address specified above. All communications received on or before the closing date for comments specified above will be considered by the Administrator before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received. All comments submitted will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested persons. A report summarizing each FAA-public contact concerned with the substance of this proposal will be filed in the Rules Docket.

Availability of NPRM

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the FAA, Northwest Mountain Region, Office of the Regional Counsel (Attn: ANM-103), Attention: Airworthines Rules Docket No. 86-NM-125-AD, 17900 Pacific Highway South, C-68966, Seattle, Washington 98168.

Discussion: The FAA issued AD 84-21-02 on October 9, 1984, which requires the incorporation of a Supplemental Structural Inspection Document (SSID) into Boeing Model 747-100SR operators' maintenance program. This existing AD identified by serial number the candidate airplanes for the SSID program. They consisted of Boeing Model 747-100 and Model 747-200 series airplanes that had accumulated more than one-half of their design life goal. This proposed AD will add the Boeing Model 747-100SR series airplanes to the SSID program.

Because of operational procedures, the pressure-critical fuselage structure and the nacelle strut structure of a significant number of Boeing Model 747-100SR series airplanes are now approaching their design life goal. It is expected that these airplanes will continue to be operated beyond this point. The incidence of fatigue cracking of the fuselage and nacelle strut on these airplanes is expected to increase as airplanes reach and exceed their goals.

Boeing has developed Document D6-35655, approved on March 22, 1986, that identifies those airplanes exceeding 12,000 landings after January 1, 1985. A list of candidate airplane serial and line numbers is listed in Boeing Document D6-35655 for the Boeing Model 747-100SR series airplanes. The candidate list will re reviewed periodically and updated if there are significant changes in fleet distribution, composition, or utilization.

To maintain adequate fleet surveillance, each operator with candidate airplanes must provide a directed inspection program for those airplanes which meet the requirements established by this document. This AD would require directed inspection programs for these airplanes (i.e. the candidate fleet), coupled with reporting of discrepancies found and, where necessary, follow-up action, to maintain structural airworthiness in the total fleet when fatigue cracking occurs.

Information collection requirements contained in this regulation have been approved by the Office of Management and Budget under the provisions of the Paperwork Reduction Act of 1980 (Pub. L. 96-511) and have been assigned OMB Control Number 2120-0056.

No airplanes of U.S. registry would be affected by this AD, therefore there is no cost impact on this AD to U.S. operators.

For the reasons discussed above, the FAA has determined that this document (1) involves a proposed regulation which is not major under Executive Order 12291 and (2) is not a significant rule pursuant to the Department of Transportation Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and it is certified under the criteria of the Regulatory Flexibility Act that this proposed rule, if promulgated, will not have a significant economic impact on a substantial number of small entities because few, if any, Boeing Model 747-100SR airplanes are operated by small entities. A copy of a draft regulatory evaluation prepared for this action is contained in the regulatory docket.

List of Subjects in 14 CFR Part 39

Aviation safety, Aircraft.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration proposes to amend § 39.13 of Part 39 of the Federal Aviation Regulations as follows:

1. The authority citation for Part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421 and 1423; 49 U.S.C. 106(g) (Revised Pub. L. 97-449, January 12, 1983); and 14 CFR 11.89.

2. By adding the following new airworthiness directive:

Boeing: Applies to Model 747-100SR series airplanes listed in section 3.0 of Boeing Document No. D6-35655 "Supplemental Structural Inspection Document" (SSID), approved March 22, 1986, certified in any category. Compliance is required as indicated in the body of the AD.

To ensure the continuing structural intergrity of these airplanes, accomplish the following, unless already accomplished:

A. Within one year after the effective date of the AD, incorporate a revision into the FAA approved maintenance inspection program which provides no less than the required damage tolerance rating (DTR) for each Structural Significant Item (SSI) listed in Boeing Document D6-35655, approved March 22, 1986, or later FAA-approved revisions. The required DTR value for each SSI is listed in the document. The revision to the maintenance program must include and be implemented in accordance with the procedures in sections 5.0 and 6.0 of the SSID.

B. Cracked structure must be repaired before further flight in accordance with an FAA approved-method.

C. Special flight permits may be issued in accordance with FAR 21.197 and 21.199 to operate airplanes to a base for the accomplishment of inspections and/or modification required by this AD.

D. An alternate means of compliance or adjustment of the compliance time, which provides an acceptable level of safety, may be used when approved by the Manager, Seattle Aircraft Certification Office, FAA, Northwest Mountain Region.

E. Operators who have acceptably incorporated Boeing Document No. D6-35655, approved March 22, 1986, or later FAA-approved revisions, into their approved maintenance program are exempt from the requirements of this AD.

The FAA has requested **Federal Register** approval to incorporate by reference the manufacturer's Supplemental Inspection Document identified and described in this proposal.

All persons affected by this proposal who have not already received the appropriate service documents from the manufacturer may obtain copies upon request to the Boeing Commerical Airplane Company, P.O. Box 3707, Seattle, Washington 98124-2207. These documents may be examined at the FAA, Northwest Mountain Region, 17900 Pacific Highway South, Seattle, Washington, or the Seattle Aircraft Certification Office, 9010 East Marginal Way South, Seattle, Washington.

Issued in Seattle, Washington, on May 27, 1986.

David E. Jones,

Acting Director, Northwest Mountain Region.

[FR Doc. 86-12323 Filed 6-2-86; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 20

[Docket No. 86N-0180]

Public Information; Proposed Amendment To Exempt Certain Memoranda of Understanding From Publication

AGENCY: Food and Drug Administration.

ACTION: Proposed rule.

SUMMARY: The Food and Drug Administration (FDA) is proposing to amend its requirements concerning publication in the **Federal Register** of written agreements and understandings between FDA and other departments, agencies, and organizations. The proposed rule would exempt memoranda of understanding between FDA and State agencies from the requirement of publication and would require only periodic publication in the **Federal Register** of a listing of all such written agreements or understandings.

DATE: Comments by August 4, 1986.

ADDRESS: Written comments to the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Robert Tucker, Division of Federal-State Relations (HFC-152), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-443-3360.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of October 3, 1974 (39 FR 35697), FDA announced that all memoranda of understanding entered into by the agency would be published in the **Federal Register** for public review. Subsequently, FDA codified the policy at 21 CFR 4.108 (39 FR 44602, 44651; December 24, 1974), which was recodified at 21 CFR 20.108 (42 FR 15553, 15625; March 22, 1977). FDA took this action because, between 1948 and 1974, the agency had entered into many international agreements with foreign countries and numerous memoranda of understanding with other Federal Government agencies. At the time, there was widespread interest on the part of consumers, industry, professional groups, associations, educators, and other government agencies in the text of these memoranda and agreements.

Since 1974, FDA has published in the **Federal Register** all memoranda of understanding into which the agency has entered, including those with State agencies. Memoranda between FDA and State agencies are work-sharing agreements that are intended to avoid duplication of inspectional activities and to coordinate responses to emergencies (e.g., recalls). Rarely is there a significant difference between the memorandum of understanding FDA enters into with one State and the memorandum of understanding the agency enters into with another State. Consequently, FDA believes that little useful purpose is served by continuing to publish in the **Federal Register** the complete text of memorandum of understanding between FDA and State agencies. Accordingly, FDA is proposing to amend § 20.108 to provide that instead of publishing each memorandum of understanding that FDA enters into with a State agency, FDA will periodically publish in the **Federal Register** a notice that will list all such memoranda of understanding currently in effect. These memoranda would remain part of the public file (see 21 CFR 10.90(d)) and, such, would remain available for public review and dissemination upon request.

Comments

Interested persons may, on or before August 4, 1986, submit to the Dockets Management Branch (address above) written comments regarding this proposal. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

List of Subjects in 21 CFR Part 20

Confidential business information, Freedom of Information.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, it is proposed that Part 20 be amended as follows:

PART 20—PUBLIC INFORMATION

1. The authority citation for 21 CFR Part 20 is revised to read as follows:

Authority: Sec. 201 et seq., Pub. L. 717, 52 Stat. 1040 et seq., as amended (21 U.S.C. 321 et seq.); sec. 1 et seq., Pub. L. 410, 58 Stat. 682 et seq., as amended (42 U.S.C. 201 et seq.); Pub. L. 90-23, 81 Stat. 54-56 as amended by 88 Stat. 1561-1565; 5 U.S.C. 552; 21 CFR 5.10.

2. In § 20.108 by revising paragraph (c) to read as follows:

§ 20.108 Agreements between the Food and Drug Administration and other departments, agencies, and organizations.

* * * * *

(c) All such agreements and understandings, except memoranda of understanding between FDA and State agencies, shall be published in the **Federal Register**. Periodically, but not less than once every 2 years, FDA shall publish a notice in the **Federal Register** listing all memoranda of understanding and agreements that are in effect between FDA and State agencies.

Dated: May 27, 1986.

Joseph P. Hile,

Associate Commissioner for Regulatory Affairs.

[FR Doc. 86-12348 Filed 6-2-86; 8:45 am]

BILLING CODE 4160-01-M

21 CFR Parts 182 and 186

[Docket No. 78N-0255]

Sodium Oleate and Sodium Palmitate; Tentative Affirmation of GRAS Status as Indirect Human Food Ingredients

AGENCY: Food and Drug Adminstration.

ACTION: Tentative final rule.

SUMMARY: The Food and Drug Admnistration (FDA) is tentatively affirming that sodium oleate and sodium palmitate are generally recognized as safe (GRAS) as indirect human food ingredients for use in paper and paperboard products used in food packaging. FDA is also tentatively affirming that sodium oleate is GRAS for use as a component of lubricants with incidental food contact. The agency has evaluated the safety of these ingredients under the comprehensive safety review conducted by the agency. FDA is publishing this document as a tentative final rule, however, because the agency has modified proposed 21 CFR 186.1770 and 186.1771 to omit specifications for sodium oleate and sodium palmitate.

DATE: Comments by August 4, 1986.

ADDRESS: Written comments to the Dockets Management Branch (HFA-305), Food and Drug Administration, room 4-62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Hortense S. Macon, Center for Food Safety and Applied Nutrition (HFF-335), Food and Drug Administration, 200 C St. SW., Washington, DC 20204, 202-472-5690.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of January 30, 1979 (44 FR 5905), FDA published a proposal to affirm that sodium oleate and sodium

palmitate are GRAS for use in paper and paperboard products used in food packaging, and that sodium oleate is GRAS for use as a component of lubricants, with incidental food contact. FDA published the proposal in accordance with its announced review of the safety of GRAS and prior-sanctioned ingredients.

In accordance with § 170.35 (21 CFR 170.35), copies of the scientific literature review on sodium oleate and sodium palmitate and the report of the Select Committee on GRAS Substances (the Select Committee) on sodium oleate and sodium palmitate are available for public review in the Dockets Management Branch (address above). Copies of these documents have also been made available for public purchase from the National Technical Information Service, as announced in the proposal.

In addition to proposing to affirm the GRAS status of sodium oleate and sodium palmitate, FDA gave public notice that it was unaware of any prior-sanctioned uses for these substances other than the proposed conditions of use. Persons asserting additional or extended uses in accordance with approvals granted by the U.S. Department of Agriculture or FDA before September 6, 1958, were given notice to submit proof of those sanctions, so that the safety of the prior-sanctioned uses could be determined. That notice was also an opportunity to have prior-sanctioned uses of sodium oleate or sodium palmitate approved by issuance of an appropriate regulation under Part 181—Prior-Sanctioned Food Ingredients (21 CFR Part 181) or affirmed as GRAS under Part 186 (21 CFR Part 186), as appropriate.

FDA also gave notice that failure to submit proof of an applicable prior sanction in response to the proposal would constitute a waiver of the right to assert the sanction at any future time.

No reports of prior-sanctioned uses for sodium oleate or sodium palmitate were received in response to the proposal. Therefore, in accordance with that proposal, any right to assert a prior sanction for uses of these ingredients under conditions different from those set forth in the regulations has been waived.

No comments were received in response to the proposal on sodium oleate and sodium palmitate. However, in a regulation published in the **Federal Register** of October 19, 1983 (48 FR 48456), FDA announced that it would only include purity specifications for substances affirmed as GRAS in Part 186 for indirect use if such purity specifications were necessary based on safety considerations. In the case of sodium oleate and sodium palmitate, the agency has concluded that purity specifications are not required to ensure safety because of the extremely small exposure to sodium oleate and sodium palmitate from their use in food-packaging materials. Therefore, the agency has modified proposed §§ 186.1770 and 186.1771 by removing the specifications that were listed in those regulations. Nonetheless, under § 186.1(a) (21 CFR 186.1(a)), the ingredients must be of a purity suitable for their intended use in accordance with the provisions of 21 CFR 186.1 and 170.30(h)(1).

In addition, FDA has combined the paragraphs that described the conditions of use of these ingredients (proposed paragraphs (c) and (d)) into a single paragraph (b). This modification conforms to the amendment of § 186.1(b)(1) that FDA adopted in 1983 (48 FR 48457; October 19, 1983).

The agency has concluded that its actions not to include specifications in the regulations affirming the GRAS status of sodium oleate and sodium palmitate and to modify the paragraph on the conditions of use of these ingredients do not represent a major change from the proposed regulations. However, to afford interested persons the opportunity to comment on these actions, FDA is issuing this tentative final rule under 21 CFR 10.40(f)(6).

The agency has determined under 21 CFR 25.24(b)(7) (April 26, 1985; 50 FR 16636) that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Therefore, neither an environmental assessment nor an environmental impact statement is required.

In accordance with the Regulatory Flexibility Act, the agency previously considered the potential effects that this tentative final rule would have on small entities, including small businesses. In accordance with section 605(b) of the Regulatory Flexibility Act, the agency has determined that no significant impact on a substantial number of small entities would derive from this action. FDA has not received any new information or comments that would alter its previous determination.

In accordance with Executive Order 12291, FDA has previously analyzed the potential economic effects of this tentative final rule. As announced in the proposal, the agency has determined that the rule is not a major rule as determined by the Order. The agency has not received any new information or comments that would alter its previous determination.

The agency's findings of no major economic impact on a substantial number of small entities, and the evidence supporting these findings are contained in a threshold assessment which may be seen in the Dockets Management Branch (address above).

Interested persons may, on or before August 4, 1986, submit to the Dockets Management Branch (address above) written comments regarding this tentative final rule. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Recieved comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

List of Subjects

21 CFR Part 182

Food ingredients, Spices and flavorings.

21 CFR Part 186

Food ingredients, Food packaging.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs and redelegated to the Center for Food and Safety and Applied Nutrition, Parts 182 and 186 would be amended as follows:

PART 182—SUBSTANCES GENERALLY RECOGNIZED AS SAFE

1. The authority citation for 21 CFR Part 182 continues to read as follows:

Authority: Secs. 201(s), 402, 409, 701, 52 Stat. 1046–1047 as amended, 1055–1056 as amended, 72 Stat. 1784–1786 as amended (21 U.S.C. 321(s), 342, 348, 371); 21 CFR 5.10 and 5.61.

§ 182.90 [Amended]

2. In § 182.90 *Substances migrating to food from paper and paperboard products* by removing the entry for "Soap (sodium oleate, sodium palmitate)" from the list of substances.

PART 186—INDIRECT FOOD SUBSTANCES AFFIRMED AS GENERALLY RECOGNIZED AS SAFE

3. The authority citation for 21 CFR Part 186 is revised to read as follows:

Authority: Secs. 201(s), 402, 409, 701, 52 Stat. 1046–1047 as amended, 1055–1056 as amended, 72 Stat. 1784–1788 as amended (21 U.S.C. 321(s), 342, 348, 371); 21 CFR 5.10 and 5.61.

4. By adding new § 186.1770 to read as follows:

§ 186.1770 Sodium oleate.

(a) Sodium oleate ($C_{18}H_{23}O_2Na$, CAS Reg. No. 143–19–1) is the sodium salt of oleic acidic (cis-9-octadecenoic-acid). It

exists as a white to yellowish powder with a slight tallow-like odor. Commercially, sodium oleate is made by mixing and heating flaked sodium hydroxide and oleic acid.

(b) In accordance with § 186.1(b)(1), the ingredient is used as a constituent of paper and paperboard used for food packaging, and a component of lubricants with incidential food contact in accordance with § 178.3570 of this chapter, with no limitation other than current good manufacturing practice.

(c) Prior sanctions for this ingredient different from the uses established in this section do not exist or have been waived.

5. By adding new § 186.1771 to read as follows:

§ 186.1771 Sodium palmitate.

(a) Sodium palmitate ($C_{16}H_{31}O_2Na$, CAS Reg. No. 408-35-5) is the sodium salt of palmitic acid (hexadecanoic acid). It exists as a white to yellow powder. Commercially, sodium palmitate is made by mixing and heating flaked sodium hydroxide and palmitic acid.

(b) In accordance with § 186.1(b)(1), the ingredient is used as a constituent of paper and paperboard for food packaging with no limitation other than current good manufacturing practice.

(c) Prior sanctions for this ingredient different from the uses established in this section do not exist or have been waived.

Dated May 15, 1986.

Richard J. Ronk,

Acting Director, Center for Food Safety and Applied Nutrition.

[FR Doc. 86-12345 Filed 6-2-86; 8:45 am]

BILLING CODE 4160-01-M

21 CFR Part 201

[Docket No. 85N-0554]

Labeling Requirements for Over-the Counter Drugs; Proposed Amendment of Statement of Identity Requirements; Extension of Comment Period

AGENCY: Food and Drug Administration.

ACTION: Notice of Proposed rulemaking; extension of comment period.

SUMMARY: The Food and Drug Administration (FDA) is extending to July 16, 1986, the comment period for the notice of proposed rulemaking to amend the labeling requirements for over-the-counter (OTC) drugs in § 201.61(b) (21 CFR 201.61(b)). This action responds to a request to extend the comment period for an additional 30 days to allow more time for interested persons to review the proposal and to prepare meaningful comments.

DATE: Written comments by July 16, 1986.

ADDRESSES: Written comments to the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: William E. Gilbertson, Center for Drugs and Biologics (HFN-210), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-295-8000.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of April 17, 1986 (51 FR 13023), FDA issued a notice of proposed rulemaking to amend the labeling requirements for OTC drugs in § 201.61(b) (21 CFR 201.61(b)), as follows: (1) To clarify that the statement of identity requirements apply to both single active ingredients and combinations of active ingredients, and (2) to state that OTC drug monographs established under Part 330 (21 CFR Part 330) are the source of the statement of identity of an OTC drug, unless otherwise stated in an approved new drug application, or unless there is no applicable monograph. Interested persons were given until June 16, 1986, to comment on the notice of proposed rulemaking.

In response to the proposal, The Proprietary Association requested a 30-day extension of the comment period in order to allow adequate time for the association to review the proposal. The Proprietary Association stated that the rulemaking is of significant interest to the OTC drug industry and that extending the comment period will allow greater participation by all those who will be affected by the proposal.

FDA has carefully considered the request. The agency believes that greater participation by those affected by the proposal is in the public interest, and may be of assistance in amending the statement of identity labeling requirements for OTC drug products. Thus, the agency considers a general extension of the comment period for 30 days to be appropriate.

Interested persons may, on or before July 16, 1986, submit to the Dockets Management Branch (address above) written comments concerning the notice of proposed rulemaking. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

Dated May 28, 1986.

John M. Taylor,

Acting Associate Commissioner for Regulatory Affairs.

[FR Doc. 86-12343 Filed 5-29-86; 10:32 am]

BILLING CODE 4160-01-M

DEPARTMENT OF THE TREASURY

Bureau of Alcohol, Tobacco and Firearms

27 CFR Part 9

[Notice No. 592]

Revision of the Boundary of the El Dorado Viticultural Area

AGENCY: Bureau of Alcohol, Tobacco and Firearms (ATF), Department of the Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: ATF is proposing to amend the approved boundary of the El Dorado viticultural area to include vineyard which was unintentionally omitted from the original petition which ATF adopted in T.D. ATF-152 (48 FR 46518). This proposal is based on a petition submitted by Mr. A.G. Boissevain, President, El Dorado Wine Grape Growers Association, Camino, California. The establishment of viticultural areas and the subsequent use of viticultural area names as appellations of origin in wine labeling and advertising will help consumers better identify wines they purchase. The use of viticultural area appellations of origin will also help wineries distinguish their products from wines made in other areas.

DATE: Written comments must be received by July 3, 1986.

ADDRESSES: Send written comments to: Chief, FAA, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms, P.O. Box 385, Washington, DC 20044-0385.

Copies of the petition and the written comments received in response to this notice will be available for public inspection during normal business hours at: ATF Reading Room, Room 4406, Ariel Rios Federal Building, 12th and Pennsylvania Avenue NW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: James A. Hunt, Coordinator, FAA, Wine and Beer Branch, (202) 566-7626.

SUPPLEMENTARY INFORMATION: The El Dorado Wine Grape Growers Association in Camino, California, petitioned ATF for the establishment of an American viticultural area to be

named "El Dorado." The El Dorado viticultural area is located within El Dorado County, east of Sacramento, California. In response to this petition, ATF published a notice of proposed rulemaking, Notice No. 439 (47 FR 55954), in the **Federal Register** on December 14, 1982, proposing the establishment of El Dorado as a viticultural area. On October 13, 1983, ATF published T.D. ATF-152 (48 FR 46518) establishing the El Dorado viticultural area. On December 13, 1984, a petition was received from Mr. A.G. Boissevain, President, El Dorado Wine Grape Growers Association, to include a vineyard just outside of the western boundary of the El Dorado viticultural area. The vineyard was unintentionally omitted when the boundaries were established along Range and Township lines rather than along a more complicated contour line of 1200 foot elevation. Mr. Boissevain stated that the petitioned for area has the same name identification, topography, soil types, amount of rainfall, elevation and temperatures as found in the El Dorado viticultural area and would be distinguished from the surrounding area.

Public Participation—Written Comments

Based on the above discussion, ATF is issuing this notice of proposed rulemaking to request comments concerning this proposed revision of the El Dorado viticultural area boundary.

ATF will not recognize any material or comments as confidential. Comments may be disclosed to the public. Any material which the respondent considers to be confidential or inappropriate for disclosure to the public should not be included in the comment. The name of any person submitting a comment is not exempt from disclosure.

Regulatory Flexibility Act

The provisions of the Regulatory Flexibility Act relating to an initial and final regulatory flexibility analysis (5 U.S.C. 603, 604) are not applicable to this proposal because the notice of proposed rulemaking, if promulgated as a final rule, will not have a significant economic impact on a substantial number of small entities. The proposal will not impose, or otherwise cause, a significant increase in reporting, recordkeeping, or other compliance burdens on a substantial number of small entities. The proposal is not expected to have significant secondary or incidental effects on a substantial number of small entities.

Accordingly, it is hereby certified under the provisions of section 3 of the Regulatory Flexibility Act (5 U.S.C. 605(b)) that this notice of proposed rulemaking, if promulgated as a final rule, will not have a signficant economic impact on a substantial number of small entities.

Executive Order 12291

In compliance with Executive Order 12291, 46 FR 13193 (1981), ATF has determined that this final rule is not a "major rule" since it will not result in;

(a) An annual effect on the economy of $100 million or more;

(b) A major increase in costs or prices for consumers, individual industries, Federal, State or lcoal government agencies,or geographic regions; or

(c) Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Paperwork Reduction Act

The provisions of the Paperwork Reduction Act of 1980, Pub. L. 96-511; 44 U.S.C. Chapter 35, and its implementing regulations, 5 CFR Part 1320, do not apply to this notice because no requirement to collect information is proposed.

List of Subjects in 27 CFR Part 9

Administrative practice and procedures, Consumer protection, Viticultural areas, Wine.

Drafting Information

The principal author of this document is James A. Hunt, FAA, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms.

Authority and Issuance

PART 9—[AMENDED]

27 CFR Part 9—American Viticultural Areas—is amended as follows:

Paragraph 1. The authority citation for Part 9 continues to read as follows:

Authority: 27 U.S.C. 205.

Para. 2. Section 9.61(c) is amended by revising paragraph (12), designating existing paragraphs (13) through (15) as (17) through (19) respectively, and adding new paragraphs (13) through (16), to read as follows:

§9.61 El Dorado.

* * * * *

(c) * * *

(12) Tehnce north along the range line to its intersection with U.S. Rute 50;

(13) Thence west along U.S. Route 50 to its intersection with Cameron Park Drive;

(14) Tehnce nosth along Camron Park Drive to its intersection with Green Valley Road;

(15) Thence east along Green Valley Road to its intersection with range line R. 10 E./ R. 9 E.;

(16) Thence north along the range line to its intersection with the township line T. 10. N./ T. 11 N.;

* * * * *

Signed: May 16, 1986.

W.T. Drake,

Acting Director.

[FR Doc. 86-12245 Filed 6-2-86; 8:45 am]

BILLING CODE 4810-31-M

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27 CFR Part 9

[Notice No. 593]

Bell Mountain Viticultural Area, Texas; Consideration of Establishment

AGENCY: Bureau of Alcohol, Tobacco and Firearms, Department of the Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Bureau of Alcohol, Tobacco and Firearms (ATF) is considering the establishment of a viticultural area in Texas to be known as "Bell Mountain." This proposal is the result of a petition submitted by Mr. Robert P. Oberhelman, a grape grower in the proposed area. The establishment of viticultural areas and the subsequent use of viticultural area names as appellations of origin in wine labeling and advertising will enable winemakers to label wines more precisely and will help consumers to better identify the wines they purchase.

Comment date: Written comments must be received by July 18, 1986.

ADDRESSES: Send written comments to: Chief, FAA, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms, P.O. Box 385, Washington, DC 20044 0385 (Notice No. 593).

Copies of the petition, the proposed regulations, the appropriate map, and the written comments will be available for public inspection during normal business hours at: ATF Reading Room, Office of Public Affairs and Disclosure, Room 4406, Ariel Rios Federal Building, 1200 Pennsylvania Avenue NW, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Steve Simon, FAA, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms, 1200 Pennsylvania Avenue NW, Washington, DC 20226 (202-566-7626).

SUPPLEMENTARY INFORMATION:

Background

ATF regulations in 27 CFR Part 4 provide for the establishment of definite viticultural areas. The regulations also allow the name of an approved viticultural area to be used as an appellation of origin on wine labels and in wine advertisements.

Part 9 of 27 CFR provides for the listing of approved American viticultural areas, the names of which may be used as appellations of origin.

Section 4.25a(e)(1), Title 27 CFR, defines an American viticultural area as a delimited grape-growing region distinguishable by geographical features. Section 4.25a(e)(2) outlines the procedures for proposing an American viticultural area. Any interested person may petition ATF to establish a grape growing region as a viticultural area. The petition should include—

(a) Evidence that the name of the proposed viticultural area is locally and/or nationally known as referring to the area specified in the petition;

(b) Historical or current evidence that the boundaries of the viticultural area are as specified in the petition;

(c) Evidence relating to the geographical features (climate, soil, elevation, physical features, etc.) which distinguish the viticultural features of the proposed area from surrounding areas;

(d) A description of the specific boundaries of the viticultural area, based on features which can be found on United States Geological Survey (U.S.G.S.) maps of the largest applicable scale; and

(e) A copy of the appropriate U.S.G.S. map(s) with the boundaries prominently marked.

Petition

ATF has received a petition from Mr. Robert P. Oberhelman, president of Oberhellmann Vineyards, proposing an area in Gillespie County, Texas, as a viticultural area to be known as "Bell Mountain." The proposed area contains about 5 square miles and is located along the southern and southwestern slopes of Bell Mountain, about 15 miles north of Fredericksburg, Texas. The petitioner states that the area's winegrape acreage consists of about 45 acres on two vineyards. There is one bonded winery operating within the area.

Name of the Area

The petitioner claims that the proposed viticultural area is known by the name of "Bell Mountain." To support this, he submitted the following evidence:

(a) Bell Mountain, which at 1,956 feet is the highest elevation in the local area, was first given this name by early settlers of the area in the mid nineteenth century.

(b) The mountain has been labeled with this name on maps of the U.S. Geological Service since the first such map published for the area in 1885.

Geography of the Area

The proposed viticultural area is distinguished geographically from the surrounding areas as follows:

(a) To the north and northeast, the area is distinguished by the steepness of the mountain slopes outside the boundaries of the area. Further, soil conditions outside the area preclude viticulture on those other slopes of Bell Mountain. The petition states: "The granite protrudes through the ground surface profusely on the Peak's northern slope, therefore making tillage impossible. For this reason, only the slopes to the south and southwest are included in the boundary of the proposed Viticultural Area."

(b) In other directions, the viticultural area is distinguished by soil types and by the topographical limits of the slopes of Bell Mountain. With respect to soil, the petition states as follows:

> The soils within the boundaries of the proposed Viticultural Area are identified on the map as "pp-Pedernales-Ponototoc Association". The description reads "Non-Calcareous, sandy, loam soils, with light sandy clay subsoil. Udic Palenstalfs; Typic Rhodustaifs". These soils are unique in the general area referred to as the "Hill Country" or the Edwards Plateau in that they are slightly acid, whereas most of the soils are calcareous, or lime-bearing.

In support of his contention, the petitioner submitted a copy of a soil map from the book, *Eastern Hill Country Resource Conservation & Development Project,* published by the U.S. Department of Agriculture in 1968. This map shows that the proposed viticultural area boundaries correspond approximately to the limits of the area with soils of the pedernales-pontotoc association. This is the only occurrence of these soils shown anywhere on that map.

(c) In addition, the petition states that "The area is drier than the Pedernales valley to its south and the Llano valley to its north. It is also cooler due to its elevation, and constant breezes."

Boundaries of the Area

The boundaries of the proposed viticultural area may be found on one U.S.G.S. map of the 7.5 minute series, titled Willow City Quadrangle. The boundaries would be as described in the proposed § 9.55.

Regulatory Flexibility Act

The provisions of the Regulatory Flexibility Act relating to an initial and final regulatory flexibility analysis (5 U.S.C. 603, 604) are not applicable to this proposal because the notice of proposed rulemaking, if promulgated as a final rule, will not have a significant economic impact on a substantial number of small entities. The proposal is not expected to have significant secondary or incidental effects on a substantial number of small entities. Further, the proposal will not impose, or otherwise cause, a significant increase in the reporting, recordkeeping, or other compliance burdens on a substantial number of small entities.

Accordingly, it is hereby certified under the provisions of Section 3 of the Regulatory Flexibility Act (5 U.S.C. 605(b)) that this notice of proposed rulemaking, if promulgated as a final rule, will not have a significant economic impact on a substantial number of small entities.

Executive Order 12291

In compliance with Executive Order 12291 of Feb. 17, 1981, the Bureau has determined that this proposal is not a major rule since it will not result in:

(a) An annual effect on the economy of $100 million or more;

(b) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographical regions; or

(c) Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domesic or export markets.

Paperwork Reduction Act

The provisions of the Paperwork Reduction Act of 1980, Pub. L. 96–511, 44 U.S.C. Chapter 35, and its implementing regulations, 5 CFR Part 1320, do not apply to this notice, because no requirement to collect information is proposed.

Public Participation—Written Comments

ATF requests comments concerning this proposed viticultural area from all interested persons. Furthermore, while this document proposes possible boundaries for the Bell Mountain viticultural area, comments concerning other possible boundaries for this viticultural area will be given consideration.

Comments received before the closing date will be carefully considered. Comments received after the closing date and too late for consideration will be treated as suggestions for possible future ATF action.

ATF will not recognize any material or comments as confidential. Comments may be disclosed to the public. Any material which the commenter considers to be confidential or inappropriate for disclosure to the public should not be included in the comment. The name of the person submitting a comment is not exempt from disclosure.

Any person who desires an opportunity to comment orally at a public hearing on these proposed regulations should submit his or her request, in writing, to the Director within the 45-day comment period. The request should include reasons why the commenter feels that a public hearing is necessary. The Director, however, reserves the right to determine, in light of all circumstances, whether a public hearing will be held.

List of Subjects in 27 CFR Part 9

Administrative practice and procedures, Consumer protection, Viticultural areas, Wine.

Drafting Information

The principal author of this document is Mr. Steve Simon of the FAA, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms.

Issuance

PART 9—AMERICAN VITICULTURAL AREAS

Accordingly, the Director proposes the amendment of 27 CFR Part 9 as follows:

Paragraph A. The authority citation for Part 9 continues to read as follows:

Authority: 27 U.S.C. 205.

Par. B. The table of sections in 27 CFR Part 9, Subpart C, is amemded to add the title of of § 9.55, to read as follows:

* * * * *

Subpart C—Approved American Viticultural Areas

Sec.

* * * * *

9.55 Bell Mountain.

* * * * *

Par. C. Subpart C of 27 CFR Part 9 is amended by adding § 9.55, which reads as follows:

§ 9.55 Bell Mountain.

(a) *Name.* The name of the viticultural area described in this section is "Bell Mountain."

(b) *Approved map.* The appropriate map for determining the boundaries of the Bell Mountain viticultural area is one U.S.G.S. map, titled: Willow City Quadrangle, 7.5 minute series, 1967.

(c) *Boundary*—(1) *General.* The Bell Mountain viticultural area is located in Gillespie County, Texas. The starting point of the following boundary description is the summit of Bell Mountain (1,956 feet).

(2) *Boundary Description*—(i) From the starting point, the boundary proceeds due southward for exactly one half mile;

(ii) Then southeastward in a straight line to the intersection of Willow City Loop Road with an unnamed unimproved road, where marked with an elevation of 1,773 feet;

(iii) Then generally southward along Willow City Loop Road (a light-duty road) to Willow City.

(iv) Then continuing southward and westward along the same light-duty road to the intersection having an elevation of 1,664 feet;

(v) Then continuing westward along the light-duty road to the intersection having an elevation of 1,702 feet;

(vi) Then turning southward along the light-duty road to the intersection having an elevation of 1,736 feet;

(vii) Then turning westward along the light-duty road to the intersection having an elevation of 1,784 feet;

(viii) Then turning southward and then westward, following the light-duty road to its intersection with Texas Highway 16, where marked with an elevation of 1,792 feet;

(ix) Then due westward to the longitude line 98° 45';

(x) Then northward along that longitude line to a point due west of an unnamed peak with an elevation of 1,784 feet;

(xi) Then due eastward to the summit of that unnamed peak;

(xii) Then in a straight line eastward to the intersection of an unnamed unimproved road with Texas Highway 16, where marked with an elevation of 1,822 feet;

(xiii) Then following that unnamed road, taking the right-hand fork at an intersection, to a point due west of the summit of Bell Mountain;

(xiv) Then due eastward to the summit of Bell Mountain.

Approved: May 19, 1986.

Stephen E. Higgins,

Director.

[FR Doc. 86-12246 Filed 6-2-86; 8:45 am]

BILLING CODE 4810-31-M

27 CFR Part 9

[Notice No. 595]

Revision of the Boundary of the Monticello Viticultural Area

AGENCY: Bureau of Alcohol, Tobacco and Firearms (ATF), Department of the Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: ATF is proposing to amend the approved boundary of the Monticello viticultural area to include vineyards which were omitted from the original petition which ATF adopted in T.D. ATF-164 (49 FR 2757). This proposal is based on a petition submitted by Edward W. Schwab, Autumn Hill Vineyards, located in Stanardsville, Virginia. The establishment of viticultural areas and the subsequent use of viticultural area names as appellations of origin in wine labeling and advertising will help consumers better identify wines they purchase. The use of viticultural area appellations of origin will also help wineries distinguish their products from wines made in other areas.

DATE: Written comments must be received by July 3, 1986.

ADDRESSES: Send written comments to: Chief, FAA, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms, P.O. Box 385, Washington, DC 20044-0385.

Copies of the petition and the written comments received in response to this notice will be available for public inspection during normal business hours at: ATF Reading Room, Room 4406, Ariel Rios Federal Building, 12th and Pennsylvania Avenue, NW, Washington, DC.

FOR FURTHER INFORMATION CONTACT: James A. Hunt, Coordinator, FAA, Wine and Beer Branch, (202) 566-7626.

SUPPLEMENTARY INFORMATION: Six wine grape growers in the Charlottesville area of Virginia first petitioned ATF to establish a viticultural area to be known as "Monticello." In response to the petition, AFT published a notice of proposed rulemaking, Notice No. 399 (46 FR 59274), on December 4, 1981, to establish a viticultural area in the Charlottesville, Virginia, area to be known as "Monticello." During the comment period The Jefferson Wine Grape Growers Society petitioned for an enlargement of the Monticello viticultural area boundary. ATF published an amended notice of proposed rulemaking, Notice No. 434 (47 FR 52200), on November 19, 1982. All the comments received favored the enlarged

boundary for the Monticello viticultural area.

On January 23, 1984, ATF published T.D. ATF-164 (49 FR 2757) establishing the Monticello viticultural area. On November 9, 1984, a petition was received from Mr. Edward W. Schwab, Managing Partner, Autumn Hill Vineyards, to include Greene County in the Monticello viticultural area. Mr. Schwab said he became aware of the Monticello viticultural area after it was established and he was not aware of the rulemaking process that had taken place.

Greene County is a small county which borders the northern boundary of the Monticello viticultural area. Mr. Schwab submitted a statement and evidence from the Virginia Cooperative Extension Service Agriculture Extension Agent that the petitioned for area has essentially the same topography, soil types, amount of rainfall, elevation and temperatures as found in the bordering Monticello viticultural area. Mr. Schwab amended his petition to exclude a montainous area in the western part of Greene County so that the revised area would be even more similar to the existing Monticello viticultural area.

The existing Monticello viticultural area is approximately 1250 square miles and therefore extends many miles from its name sake and home of Thomas Jefferson in Charlottesville, Virginia. The evidence during the rulemaking process established that the Monticello name extends throughout Central Virginia, to include Albemarle, Orange, Nelson and Greene Counties, because of Thomas Jefferson's dominant influence in the region. Historical publications have numerous references to Jefferson leasing farm land throughout Central Virginia to expand his Monticello acreage. Other references list Monticello as the primary source of crop experimentation data and planting material (including grapevines) used to start new farms in Central Virginia.

One current example which shows that the name identification extended several miles to the north of Monticello to Orange and Greene Counties is a mansion similar in appearance to Monticello which Jefferson designed for his friend, James Barbour. The mansion burned in 1884, but all the brick structure and columns remain making the structure easily identified with Monticello. This mansion, the Barboursville Ruins, is now a historical landmark and tourist attraction. The eastern boundary of the proposed amended viticultural area revision is near the Barboursville Ruins.

Public Participation—Written Comments

Based on the above discussion, ATF is issuing this notice of proposed rulemaking to request comments concerning this proposed revision of the Monticello viticultural area boundary.

ATF will not recognize any material or comments as confidential. Comments may be disclosed to the public. Any material which the respondent considers to be confidential or inappropriate for disclosure to the public should not be included in the comment. The name of any person submitting a comment is not exempt from disclosure.

Regulatory Flexibility Act

The provisions of the Regulatory Flexibility Act relating to an initial and final regulatory flexibility analysis (5 U.S.C. 603, 604) are not applicable to this proposal because the notice of proposed rulemaking, if promulgated as a final rule, will not have a significant economic impact on a substantial number of small entities. The proposal will not impose, or otherwise cause, a significant increase in reporting, recordkeeping, or other compliance burdens on a substantial number of small entities. The proposal is not expected to have significant secondary or incidental effects on a substantial number of small entities.

Accordingly, it is hereby certified under the provisions of section 3 of the Regulatory Flexibility Act (5 U.S.C. 605(b)) that this notice of proposed rulemaking, if promulgated as a final rule, will not have a significant economic impact on a substantial number of small entities.

Executive Order 12291

In compliance with Executive Order 12291, 46 FR 13193 (1981), ATF has determined that this final rule is not a "major rule" since it will not result in;

(a) An annual effect on the economy of $100 million or more;

(b) A major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or

(c) Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export merkets.

Paperwork Reduction Act

The provisions of the Paperwork Reduction Act of 1980, Pub. L. 96-511, 44 U.S.C. Chapter 35, and its implementing regulations, 5 CFR 1320, do not apply to this notice because no requirement to collect information is proposed.

List of Subjects in 27 CFR Part 9

Administrative practice and procedures, Consumer protection, Viticultural areas, Wine.

Drafting Information

The principal author of this document is James A. Hunt, FAA, Wine and Beer Branch, Bureau of Alcohol, Tobacco and Firearms.

Authority and Issuance

PART 9—[AMENDED]

27 CFR Part 9—American Viticultural Areas is amended as follows:

Paragraph 1. The authority citation for Part 9 continues to read as follows:

Authority: 27 U.S.C. 205.

Par. 2. Section 9.48(c) is revised to add the amended boundaries and by adding numbers to the descriptions to read as follows:

§ 9.48 Monticello.

* * * * *

(c) Boundaries. (1) From Norwood, Virginia, following the Tye River west and northwest until it intersects with the eastern boundary of the George Washington National Forest; (2) following this boundary northeast to Virginia Rt. 664; (3) then west following Rt. 664 to its intersection with the Nelson County line; (4) then northeast along the Nelson County line to its intersection with the Albemarle County line at Jarman Gap; (5) from this point continuing northeast along the eastern boundary of the Shenandoah National Park to its intersection with the northern Albemarle County line; (6) continuing northeast along the Greene County line to its intersection with Virginia Rt. 33; (7) follow Virginia Rt. 33 east to the intersection of Virginia Rt. 230 at Stanardsville; (8) follow Virginia Rt. 230 north to the Greene County line (the Conway River); (9) following the county line southeast to its intersection with the Orange County line, (10) continuing north on the county line to its intersection with the Rapidan River, whic continues as the Orange County line; (11) following the river east and northeast to its confluence with the Mountain Run River; (12) then following the Mountain Run River southwest to its intersection with Virginia Rt. 20; (13) continuing southwest along Rt. 20 to the corporate limits of the town of Orange; (14) following southwest the corporate limit line to its intersection with U.S. Rt. 15; (15) continuing southwest on Rt. 15 to its intersection with Virginia Rt. 231 in

the town of Gordonsville; (16) then southwest along Rt. 231 to its intersection with the Albemarle County line; (17) continuing southwest along the the county line to its intersection with the James River; (18) then following the James River to its confluence with the Tye River at Norwood, Virginia, the beginning point.

Signed: May 27, 1986.

Stephen E. Higgins,

Director;

[FR Doc. 86-12410 Filed 6-2-86; 8:45 am]

BILLING CODE 4810-31-M

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 901

Withdrawal of a Proposed Rulemaking To Amend the Alabama Permanent Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement (OSMRE), Interior.

ACTION: Withdrawn of a Proposed rule.

SUMMARY: OSMRE is announcing the withdrawal of a proposed rulemaking for an amendment submitted by the State of Alabama to amend its permanent regulatory program (hereinafter referred to as the Alabama program). The proposed amendment concerned requirements for operations extracting coal incidental to extraction of other minerals (Sub-chapter 880-X-2E of the Alabama Surface Mining Commission regulations). The proposed amendment was withdrawal by the State in a letter to OSMRE dated May 7, 1986.

DATE: This withdrawal is effective June 3, 1986.

FOR FURTHER INFORMATION CONTACT: Mr. John T. Davis, Director, Birmingham Field Office, Office of Surface Mining Reclamation and Enforcement, 228 West Valley Avenue, 3rd Floor, Homewood, Alabama 35209; Telephone: (205) 731-0890.

SUPPLEMENTARY INFORMATION: On December 30, 1985, Alabama submitted a proposed amendment to its approved regulatory program to modify requirements for operations extracting coal incidental to extraction of other minerals (Sub-chapter 880-X-2E of the Alabama Surface Mining Commission rules). The proposed rules outlined the information requirements necessary for such extraction, and criteria to be used by the Alabama Surface Mining Commission (ASMC) to determine the eligibility of the proposed operation for exemption from regulatory requirements for surface coal mining operations under the Alabama program. The proposed rules replaced rules previously approved by OSMRE (July 19, 1985, 50 FR 29379).

On January 30, 1986, OSMRE published a notice in the **Federal Register** announcing receipt of the amendment and soliciting public comment on its adequacy. The comment period ended on March 3, 1986.

On May 7, 1986, Alabama submitted a copy of Alabama Senate Bill 445, Act 86-106, which had been passed by the Alabama Legislature and which in part repealed rule 880-X-2E. In a letter which accompanied the Senate Bill, Alabama therefore withdrew the proposed amendment at ASMC 880-X-2E.

Dated: May 28, 1986.

H. Leonard Richeson,

Acting Assistant Director, Program Operations.

[FR Doc. 86-12371 Filed 6-2-86; 8:45 am]

BILLING CODE 4310-05-M

National Park Service

36 CFR Parts 1 and 3

Permit Requirements; Penalty Provisions

AGENCY: National Park Service, Interior.

ACTION: Proposed rule.

SUMMARY: This proposed rulemaking clarifies the penalty provisions of the three general regulations used by the National Park Service as basic authorities to issue and require permits for members of the public to engage in certain activities. These provisions were inadvertently omitted when the regulations were originally promulgated in 1983. Experience since that time has shown that these clarifications are necessary in order to outline the mandatory aspects of permit systems established and used by park managers to manage visitor use activities in park areas. This rulemaking is a clarification only and does not impose new restrictions or requirements.

DATE: Written comments will be accepted until July 3, 1986.

ADDRESS: Comments should be addressed to: Associate Director, Park Operations, National Park Service, P.O. Box 37127, Washington, DC 20013-7127.

FOR FURTHER INFORMATION CONTACT: Andy Ringgold, National Park Service, Branch of Ranger Activities, P.O. Box 37127, Washington, DC 20013-7127, Telephone: 202-343-1360.

SUPPLEMENTARY INFORMATION:

Background

On June 30, 1983, the National Park Service (NPS) published a major revision of its general regulations in Title 36 of the Code of Federal Regulations that pertain to resource protection, public use and recreation (48 FR 30252). One of these regulations, § 1.6, provides the general procedures and criteria under which NPS permits are issued. Another, § 1.5, sets forth the basic authority for park managers to establish permit systems in order to implement public use limits. A third general regulation, § 3.3, authorizes the superintendent to issue permits to manage boating activities within a park area.

These three regulations all contain provisions that address a superintendent's authority to issue permits and/or to establish permit conditions; other provisions prohibit violating the terms and conditions of a permit. Both §§ 1.5 and 3.3 make reference to the permit criteria and procedures of § 1.6. However, none of these sections contains text that clearly indicates that, if a permit is required by a superintendent in order for a person to engage in a certain activity, failure to obtain a permit prior to engaging in that activity constitutes a violation of the regulation by that individual.

The original intent of the NPS was that such a provision was understood as being inherent in the fact that the superintendent was authorized to require a permit. However, in the period since the effective date of these regulations, questions raised by members of the public, NPS employees and some U.S. Magistrates have indicated that this intention was not clear and that clarifying text is necessary.

This rulemaking proposes to clarify NPS permit requirements by consolidating all the general procedural and regulatory provisions pertaining to NPS permit systms and authorities found in these three sections in section 1.6 and deleting duplicative provisions from §§ 1.5 and 3.3. A provision emphasizing the mandatory nature of permit requirements has been added to section 1.6. Clarifying text has also been added to § 1.6(e) that indicates that terms and conditions of a permit may derive not only from the criteria presently specified in that paragraph but also from criteria and restrictions that exist in other regulations.

These proposed changes do not add new obligations or impose new restrictions. The intent of this

rulemaking is solely one of clarification. A minor technical change is also included in this rulemaking to revise the authority citation in 36 CFR Part 3 to reflect the statutory authority found in 16 U.S.C. 1a–2(h) that authorizes the NPS to regulate boating activities in park areas.

Public Participation

The policy of the National Park Service is, whenever practicable, to afford the public an opportunity to participate in the rulemaking process. Accordingly, interested persons may submit written comments regarding this proposed regulation to the address noted at the beginning of this rulemaking.

Drafting Information

The author of this rulemaking is Andy Ringgold of the NPS Branch of Ranger Activities, Washington, DC.

Paperwork Reduction Act

This rule does not contain information collection requirements which require approval by the Office of Management and Budget under 44 U.S.C. 3501 *et seq.*

Compliance with Other Laws

The Department of the Interior has determined that this document is not a major rule under Executive Order 12291 (February 19, 1981), 46 FR 13193, and certifies that this document will not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). These determinations are based on the fact that this rulemaking is a clarification only and has no economic effect.

The National Park Service has determined that this proposed rulemaking will not have a significant effect on the quality of the human environment, health and safety because it is not expected to:

(a) Increase pubic use to the extent of compromising the nature and character of the area or causing physical damage to it;

(b) Introduce noncompatible uses which might compromise the nature and characteristics of the area, or cause physical damage to it;

(c) Conflict with adjacent ownerships or land uses; or

(d) Cause a nuisance to adjacent owners or occupants.

Based on this determination, this proposed rulemaking is categorically excluded from the procedural requirements of the National Environmental Policy Act (NEPA) by Departmental regulations in 516 DM 6, (49 FR 21438). As such, neither an Environmental Assessment nor an Environmental Impact Statement has been prepared.

List of Subjects

36 CFR Part 1

National parks, Penalties.

36 CFR Part 3

Marine safety, National parks.

In consideration of the foregoing, it is proposed to amend 36 CFR Chapter I as follows:

PART 1—GENERAL PROVISIONS

1. The authority citation for Part 1 continues to read as follows:

Authority: 16 U.S.C. 1, 3, 9a, 460*l*–6a(e), 462(k).

2. By revising paragraph (f) § 1.5 to read as follows:

§ 1.5 Closures and public use limits.

* * * * *

(f) Violating a closure, designation, use or activity restriction or condition, schedule of visiting hours, or public use limit is prohibited.

3. By revising § 1.6(e), (g) and (h) to read as follows:

§ 1.6 Permits.

* * * * *

(e) The superintendent shall include in a permit the terms and conditions that the superintendent deems necessary to protect park resources or public safety and may also include terms or conditions established pursuant to the authority of any other section of this chapter.

* * * * *

(g) The following are prohibited:

(1) Engaging in an activity subject to a permit requirement imposed pursuant to this section without obtaining a permit; or

(2) Violating a term or condition of a permit issued pursuant to this section.

(h) Violating a term or condition of a permit issued pursuant to this section may also result in the suspension or revocation of the permit by the superintendent.

PART 3—BOATING AND WATER USE ACTIVITIES

4. The authority citation for Part 3 is revised to read as follows:

Authority: 16 U.S.C. 1, 1a-2(h), 3.

5. By revising § 3.3 to read as follows:

§ 3.3 Permits.

The superintendent may require a permit for use of a vessel within a park area in accordance with the criteria and procedures of § 1.6 of this chapter.

Dated: May 3, 1986.

Daniel Smith,

Deputy Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 86–12427 Filed 6–2–86; 8:45 am]

BILLING CODE 4310–70–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR 261

[SW–FRL–3024–8]

Hazardous Waste Management System; Identification and Listing of Hazardous Waste

AGENCY: Environmental Protection Agency.

ACTION: Proposed rule and request for comment.

SUMMARY: The Environmental Protection Agency (EPA) is today proposing to amend the regulations for hazardous waste management under the Resource Conservation and Recovery Act (RCRA) by designating as hazardous waste (rather than acute hazardous waste) the scrubber water generated by EPA's Combustion Research Facility (CRF) located in Jefferson, Arkansas as a result of burning certain dioxin-containing wastes. The Agency further proposes to re-designate all scrubber water that will be generated from burning listed dioxin-containing wastes at this facility from acute hazardous waste (H) to hazardous waste (T) based upon the testing conditions specified elseqhere in this notice. This action is in response to a petition submitted under 40 CFR 260.20, which allows any person to petition the Administrator to modify or revoke any provision of Parts 260 through 265, 124, 270, and 271 of Title 40 of the Code of Federal Regulations, and 40 CFR 260.22, which specifically provides generators the opportunity to petition the Administrator on a "generator-specific basis". The effect of this action, if promulgated, would be to allow CFR to manage their waste in accordance with the waste management standards contained in 40 CFR Parts 264 and 265 allowed for all other hazardous wastes.

DATES: EPA will accept public comments on this proposed exclusion until July 3, 1986. Comments postmarked after the close of the comment period will be stamped "late".

Any person may request a hearing on this proposed exclusion by filing a request with Eileen B. Claussen, whose address appears below, by June 18, 1986. The request must contain the information prescribed in 40 CFR 260.20(d).

ADDRESSES: Comments should be sent to the Docket Clerk, Office of Solid Waste (WH-562), U.S. Environmental Protection Agency, 401 M Street SW., Washington, DC 20460. Requests for a hearing should be addressed to Eileen B. Claussen, Director, Characterization and Assessment Division, Office of Solid Waste (WH-562B), U.S. Environmental Protection Agency, 401 M Street SW., Washington, DC 20460. Communications should identify the regulatory docket number: "F-86-CRFP-FFFFF".

The public docket for this proposed rule is located in the Sub-basement, U.S. Environmental Protection Agency, 401 M Street SW., Washington, DC 20460, and is available for viewing from 9:30 a.m. to 3:30 p.m., Monday through Friday, excluding Federal holidays. Call Mia Zmud at (202) 475-9327 of Kate Blow (202) 382-4675 for appointments. The public may copy a maximum of 50 pages of material from any one regulatory docket at no cost. Additional copies cost $.20 per page.

FOR FURTHER INFORMATION CONTACT: RCRA Hotline, toll free at (800) 424-9346, or at (202) 382-3000. For technical information, contact Dr. Doreen Sterling, Office of Solid Waste (WH-562B), U.S. Environmental Protection Agency, 401 M Street SW., Washington, DC 20460, (202) 475-8551.

SUPPLEMENTARY INFORMATION:

Background

On January 14, 1985, EPA published a final rule ("the dioxin rule") designating as acute hazardous waste, certain wastes containing tetra-, penta-, and hexachlorinated dibenzo-p-dioxins (CDDs), -dibenzofurans (CDFs), and certain chlorinated phenols (See 50 *FR*, 1978-2006). These regulations also specified certain management standards for these wastes. For incineration, the regulations specify that these wastes must be managed at fully permitted incinerators that have been certified by the Assistant Administrator for Solid Waste and Emergency Response to achieve 99.9999% (six 9s) destruction and removal efficiency (DRE) for the CDDs and CDFs or for principal organic hazardous constituent(s) (POHCs) which are as difficult or more difficult or more difficult to incinerate than the CDDs and CDFs.

Under 40 CFR 261.3(c)(2)(i), any residue derived from the treatment of a hazardous waste is a hazardous waste unless otherwise designated, or delisted under the provisions of 40 CFR 260.20 and 260.22. EPA has interpreted this to mean that the residues resulting from the incineration of listed acute hazardous waste (*i.e.*, dioxin wastes) are still acute hazardous wastes, unless otherwise designated or delisted. (In the dioxin regulation, the Agency designated the residues resulting from six 9's incineration or thermal treatment of dioxin-contaminated soils as toxid wastes (EPA Hazardous Waste No. F028). This waste therfore can be managed at interim status facilities and at fully permitted facilities not required to meet the special standards for other listed dioxin-containing wastes.)

Therefore, the wastes covered by the "dioxin rule" (except as otherwise indicated) are considered to be acute hazardous wastes because of the presence of the CDDs/CDFs. The Agency recognizes that an individual facility may demonstrate through representative sampling and analysis that the waste does not contain CDDs/CDFs at concentrations that would cause the waste to be designated as an acute hazardouse waste. The consequence of this reclassification would be that such wastes would not be subject to the more stringent management requirement for fully permitted facilities mandated by the "dioxin rule", and also can be managed at interim status facilities. This is because the Agency would be determining that the CDDs and CDFs in such wastes can be managed so as to protect human health and the environment without extraordinary precautions required for acute hazardous waste containing much higher concentrations of CDDs and CDFs.

Petitioner

The proposed re-designation published today involves EPA's Combustion Research Facility (CFR) located in Jefferson, Arkansas.

I. Combustion Research Facility

A. Petition for Exclusion

The Environmental Protection Agency, Combustion Research Facility (CRF), located in Jefferson, Arkansas, is a research facility involved in studying the feasibility of incineration of hazardous waste. Most of the waste that CRF is currently evaluating is from clean up operations at Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) sites. One of the wastes incinerated by CRF was toluene still bottoms from 2,4,5-trichlorophenol (2,4,5-TCP) production previously generated at the Vertac Chemical Company site in Jacksonville, Arkansas (referred to as the "Vertac Waste"). The CRF has petitioned the Agency to re-designate the scrubber water that has resulted from the incineration of the "Vertac" Waste from acute hazardous waste (H) to toxic waste (T). This waste is listed as EPA Hazardous Waste No. F020—Wastes (except wastewater and spent carbon from hydrogen chloride purification) from the production or manufacturing use (as a reactant, chemical intermediate, or component in a formulating process) of tri- or tetrachlorophenol, or of intermediates used to produce their pesticide derivatives. The scrubber water is currently designated as an acute hazardous waste becasuse of the presence of CDDs and CDFs and, as such, the waste is subject to more stringent management standards. CRF claims, however, that the scrubber water does not contain the CDDS/CDFs at levels of regulatory concern (although the waste may still be hazardous because it may still exhibit the characteristics of a hazardous waste or contain other toxicants at levels of regulatory concern). CFR has further petitioned the Agency to re-designate from acute hazardous waste (H) to toxic waste (T) all scrubber water generated by this incinerator when burning the listed dioxin-containing wastes based on a testing requirement for CDDs/CDFS. (It should be noted that this petition does not cover any ash, filters, or any other solid residues generated by this incinerator.)

In support of their petition, CFR has submitted: a detailed description of their incinerator, including schematic diagrams, an engineering description, and the incinerator operating conditions; a general characterization of the "Vertac" waste that was incinerated; and analytical test results on CDD/CDF concentrations in the scrubber water generated from burning the "Vertac waste" after carbon filtration.

Description of the Incinerator. The rotary kiln incineration system at CRF consists of a rotary kiln primary combustion chamber, a fired afterburner, and a primary air pollution control system consisting of a quench elbow and venturi scrubber followed by a packed tower scrubber. In addition, a back up air pollution control system consisting of a carbon-bed absorber and a High Efficiency Particulate Air Pollution Control Device (HEPA) filter is in place. Scrubber blowdown also

passes through a carbon filter before storage in the blowdown tanks.

During this test burn, the operating temperature was maintained at 1800°F for the kiln and 2030°F for the afterburner. The calculated residence time in the kiln main chamber ranged between 4.9 to 6.0 seconds, while the residence time in the afterburner ranged from 1.8 to 2.3 seconds.

For these tests, waste was introduced at the feed face through the front face line with a Moyno pump at a mean feed rate of 22 lb. per hour for burn 1 and 39 lb. per hour for burn 2. Auxiliary fuel (propane) was fired through a burner located at the transfer duct end of the kiln. The afterburner was also fired with auxiliary fuel.

7000 gallons of filtered blowdown water, generated from the incineration of the "Vertac" waste, is currently contained in the blowdown tanks. It is this water which is the subject of this notice. In addition, CRF is also requesting a re-designation of all scrubber water generated by this incinerator during subsequent research burns of the listed dioxin-containing wastes provided the scrubber water meets certain testing requirements.

Description of the Waste. The approximate composition of the 2,4,5-TCP/toluene still bottoms (the "Vertac" waste) contaminated with CDDs/CDFs that was incinerated by CRF is presented in Table 1. This waste was reported to contain approximately 40 ppm of 2.3,7,8-TCDD.

TABLE 1.—*Estimated Composition of Stillbottoms*

Compound	Composition (percent)
Methanol	1
Toluene	8
Dichlorobenzenes	1.5
Trichlorobenzenes	1.5
2,4,5-Trichloroanisole	56
Na-trichlorophenol	7
Dichlorodimethoxy-benzene	18
2,4,5-T, Na salt	7

Sampling and Analysis. The total volume of water generated during the incineration of the "Vertac Waste" is stored in two holding tanks. (4,000 gallons in one tank and 3,000 gallons in the other tank.) The tanks were sampled after completion of the entire burn series. Eight composite samples were taken. For each composite, 60% was obtained from the larger tank while 40% of the sample was obtained from the smaller tank, thus representing a weighted average (*i.e.*, 4,000/7,000≅60% 3,000/7,000≅40%). Both tanks were sampled by Dipper Method (See SW-846, Test Methods for Evaluating Hazardous Wastes, July, 1982) from the top of the tank while the water was recirculated (duration about 20 hrs.) at 53 gal/min. Four of the samples were analyzed for CDDS/CDFs by High Resolution Gas Chromatography/High Resolution Mass Spectrometry (HRGC/HRMS). The other four samples remained on site as archives. The results of their analyses are presented in Table 2.

TABLE 2.—*Maximum Concentrations of CDDs/CDFs*

Isomer/homolog	Concentration pg/ml (ppt) [1] [2]
2,3,7,8-TCDD	0.12
TetraCDD (TCDD)	0.12
PentaCDD (PCDD)	(0.012)
HexaCDD (HxCDD)	(0.020)
2,3,7,8-TCDF	(0.011)
TetraCDF (TCDF)	0.23
PentaCDF (PCDF)	0.013
HexaCDF (HxCDF)	(0.009)

[1] Numbers in parentheses are detection limits.

[2] Data was also reported on the hepta- and octa- isomers; these data were not included in this table since these homologs are not covered by the original listing. In addition, since these isomers are not on Appendix VIII of Part 261 (*i.e.*, the list of hazardous constituents identified by the Agency), we have not included them in our evaluation.

B. Agency Analysis and Action

The CRF has demonstrated through analysis of representative samples that the 7000 gallons of scrubber water, generated during the incineration of the "VERTAC waste", is not an acute hazardous waste. The Agency believes that the grab samples collected from the two blowdown tanks are biased and adequately represent any variations which may occur in the waste. The Agency is satisfied that the grab samples do not mask any possible variability in the waste because: (1) the tanks contained the entire volume of water generated during the Vertac burns, (2) the tanks were sampled after completion of the burns, and (3) the tanks were well mixed prior to and during sampling.

The Agency has evaluated the analytical data provided by CRF on the CDD/CDF homologs. The Agency has used the hazard evaluation procedure developed by the Agency's Chlorinated Dioxins Workgroup (CDWG) to assess the risks associated with exposure to the CDDs and CDFs in these residues.[1] The procedure, which involves the evaluation of the toxicity of a mixture of CDDs and CDFs by estimation of 2,3,7,8-TCDD equivalents, is based on structure-activity relationships using their carcinogenic, reproductive, and biochemical effects. 2,3,7,8-TCDD equivalents are calculated by summing the products of the concentration of each homolog and its toxic equivalents (TEF). The product is the 2,3,7,8-TCDD equivalent for each homolog; the sum of the products is the 2,3,7,8-TCDD equivalent concentration of the mixture. The 2,3,7,8-TCDD equivalents estimate for the wastewater is given in Table 3. (As is the Office of Solid Waste's (OSW) practice, the detection limit is used as the possible upper limit of exposure for purposes of hazard evaluation when a constituent is not detected.)

TABLE 3.—CALCULATION OF TOXIC EQUIVALENCE FACTOR (TEF)

Homolog	Maximum reported concentration, ppt [1]	TEF	TCDD equivalents
TCDD	0.12	1	0.1
PCDD	(0.01)	0.5	0.005
HxCDD	(0.02)	0.04	0.008
TCDF	0.23	0.1	0.02
PCDF	0.01	0.1	0.001
HvCDF	(0.01)	0.01	0001
Total			0.1 ppt

[1] Numbers in parentheses indicate detection limits.

The Agency believes that this waste can safely be managed as a hazardous (T) waste without the special management controls required for an acute hazardous waste due to the low level of 0.1 ppt TCDD equivalents in the scrubber water. EPA determined that special controls were needed for certain of the listed dioxin-containing wastes in light of the high concentrations of CDDs and CDFs found in the wastes before treatment (50 FR 1985). When these concentrations are greatly reduced by treatment, as in CFR's waste, the residual waste presents much less risk and can be safely managed in the same manner as other hazardous wastes (Id. at 1995). The Agency already has acknowledged that less stringent standards are appropriate for less contaminated, dioxin-containing wastes. In particular, the "dioxin rule", promulgated on January 14, 1985 (see 50 *FR* 1978–2006), designated as hazardous (T) (as opposed to acute hazardous (H)), residues resulting from the incineration or thermal treatment of dioxin-contaminated soils. These residues are allowed to be managed at interim status land disposal facilities and at treatment, storage, or disposal facilities pursuant to the usual Part 264 standards (*i.e.*, not meeting the special standards for other dioxin-containing wastes, such as

[1] Chlorinated Dioxins Workgroup Position Document, "Interim Procedures for Estimating Risk Associated with Exposures to Mixtures of Chlorinated Dioxins and -Dibenzofurans (CDDs and CDFs), November 21, 1985.

secondary containment or a waste management plan). EPA's rationale for this decision was that the concentration of TCDD in the residue from incineration of soils will be less than 1 ppb. This concentration in soil was determined to be a reasonable level at which to consider limiting human exposure in a residential setting.[2] EPA, therefore, concluded that the residues from incineration or thermal treatment of CDD/CDF contaminated soils, present much less risk than the untreated soils, and thus, could be managed safely at normal hazardous waste management facilities.

In a later notice (September 12, 1985, 50 *FR* 37338–37342), the Agency proposed to extend this idea by proposing to re-designate the residues resulting from the incineration of certain dioxin-containing wastes as hazardous (T) when the waste that is incinerated contains less [3] than 10 ppm TCDD equivalents (the "residue rule"). The basis for this proposed decision was that the residues would contain less than 0.1 ppb of TCDD equivalents, a concentration well below the 1 ppb level cited above. There was substantial concensus in the comments to this proposed rule that dioxin-containing wastes did not require extraordinary management controls when concentrations were below 1 ppb.

EPA is tentatively of the view that the level for designating scrubber effluent as toxic should be lower than the level for solid matrices. This is because CDDs/CDFs in liquid are already mobile. Consequently, EPA views 10 ppt as an appropriate level for scrubber effluent. This level is two orders of magnitude less than the 1 ppb level cited above.

The Agency's proposed decision here to re-designate the 7000 gallons of scrubber water is therefore based on the belief that wastes containing less than 10 ppt TCDD equivalents can be managed safely at interim status facilities, and at fully permitted facilities without waste management plans. In particular, the potential risk resulting from exposure to a contaminant depends on the route of exposure and the matrix of which the contaminant is a part. This is particularly true for dioxins since bioavailability, which is matrix-dependent, is a significant factor in determining these levels. The exposure pathways of most concern for the CDDs/CDFs are postulated to result from the contamination of husbandry and stream sediment by CDD/CDF-contaminated soil dispersed from the disposal site by rain, flood water, or wind. Leaching of CDDs/CDFs to ground water is also of concern, however. The Agency believes that adequate controls currently exist at interim status facilities to control surface run-off/run and wind dispersal (see, *e.g.*, 40 CFR § 265.302), in light of the low concentrations of CDDs/CDFs found in this scrubber water. We also believe that because of the low concentrations of the CDDs/CDFs, interim status facilities should control the leaching of CDDs/CDFs to ground water until final permits are issued. We note further that non-dioxin containing wastes which are more hazardous than this scrubber water (due to high concentrations of other toxicants) are not required to be managed pursuant to special standards. EPA believes that this redesignated scrubber water thus is more appropriately managed pursuant to the same standards to which these other toxic hazardous wastes are subject.

The level reported in CRF's waste was 0.1 ppt of TCDD equivalents; this is two orders of magnitude lower than the 10 ppt level that the Agency believes can be safely handled without the special management standards required for the listed dioxin wastes. EPA, therefore, does not believe that CRF's scrubber water is an acute hazardous waste requirng the heightened regulatory controls and can thus be redesignated as hazardous (T).[4]

Note, however, that it is still EPA's conclusion that these wastes are still hazardous due to their CDD/CDF content and thus still require the same level of management as other hazardous waste. In particular, on January 14, 1986, the Agency proposed its framework for a regulatory program to implement the congressionally mandated land disposal prohibitions (see 51 *FR* 1602–1766). The ban rule sets a screening level of 4 ppg for the 2,3,7,8-TCDD isomer using the TEFs. This level was based upon an estimate for the allowable concentration of TCDD in potable ground water of 0.2 ppg.

This concentration is the 10^{-6} risk level dose in water based upon a 70 kg man consuming 2L of water per day over a 70 year lifetime. This concentration is two orders of magnitude less than the action level for acute hazardous versus toxic we are positing here. Although one can assume some attenuation in the event of release, not enough information is currently available on attenuation mechanisms (*e.g.*, dilution when discharged to surface water, etc.) to conclude that the concentrations of CDDs/CDFs would be reduced two orders of magnitude to levels of non-regulatory concern. Based on the above considerations, the Agency believes that the scrubber water still requires control as a hazardous waste by virtue of its CDD and CDF content.

The Agency is also proposing today to re-designate (as toxic (T)) all carbon filtered scrubber water that will be generated by CRF's incinerator contingent upon the testing of each tank of water for the CDD/CDF homologs and that the TCDD equivalents of each tank does not exceed 10 ppt. A detection limit of about 5 ppt for each homolog in a carbon treated aqueous matrix is achievable by EPA's test mentod 8280 (this method involves sample clean-up followed by HRGC/LRMS analysis).[5] The Agency believes as previously described that this level will be protective of human health and the environment when the waste is managed in accordance with the general waste management standards. It should be noted that in both the September 12, 1985 notice and in this preamble, we indicate that below 0.1 ppt of TCDD-equivalents, a dioxin-containing waste can be managed without the special management standards (*i.e.*, secondary containment or a waste management plan). As noted above, since the CDDs/CDFs in the scrubber water are more likely to escape from the waste and get into the environment than CDDs/CDFs in a solid matrix, we believe a lower level would be more protective. We therefore selected a level of 10 ppt since this level (in our opinion) would provide a greater margin of safety in managing this waste at interim status facilities. Considering the toxicity of these compounds, such a distinction is appropriate. In addition, we believe that any incinerator that is operating properly and achieving six 9's DRE should easily achieve this level. The Agency, however, solicits comment on this level.[6] Thus, if the level in CRF's

[2] USDDHS. 1984. Health Risk Estimate for 2,3,7,8-TCDD in soil. Morbidity and mortality weekly report 33:258.

[3] CRF's waste contains approximately 40 ppm of 2,3,7,8-TCDD and is thus not covered by the proposed "residue rule".

[4] The Agency is proposing to add a new waste to the hazardous waste list (EPA Hazardous Waste No. F031) to make it clear that these wastes will be considered as toxic (T).

[5] A limit of 1 ppb for each homolog in the leachate was proposed in the land disposal restrictions rule (51 *FR* 1734). Even though lower detection levels are achievable, test method 2880 is expected to perform more reliably on a routine basis at a limit of 1 ppb.

[6] The Agency plans to solicit comments in a future notice to extend the r roposed September 12,

Continued

scrubber water exceed 10 ppt of TCDD equivalents, the waste must either be retreated or be managed as an acute hazardous waste.

II. Effective Date

This rule, if promulgated, will become effective immediately. Although subtitle C regulations normally take effect six months from promulgation (RCRA section 3010 (b)), the Hazardous and Solid Waste Amendments of 1984 amended Section 3010 of RCRA to allow rules to become effective in less than six months when the regulated community does not need the six month period to come into compliance. That is the case here since this rule reduces, rather than increases the existing requirements for persons generating hazardous wastes. In light of the unecessary hardship and expense which would be imposed on the petitioner by an effective date six months after promulgation and the fact that such a deadline is not necessary to achieve the purpose of section 3010, we believe that these rules should be effective immediately. These reasons also provide a basis for making this rule effective immediately under the Administrative Procedure Act, pursuant to 5 U.S.C. Sec. 553(d).

III. Regulatory Impact

Under Executive Order 12291, EPA must judge whether a regulation is "major" and therefore subject to the requirement of a Regulatory Impact Analysis. this proposal is not major since its effect is to reduce the overall costs and economic impact of EPA's hazardous waste management regulations. This reduction is achieved by re-designating the scrubber water from acute hazardous waste (H) to hazardous waste (T) at CRF's facility in Jefferson, Arkansas and thereby enabling the facility to manage its waste in accordance with the general waste management standards. Since this rulemaking is not a major rule, a regulatory impact analysis was not conducted.

IV. Regulatory Flexibility Act

Pursuant to the Regulatory Flexibility Act, 5 U.S.C. 601–612, whenever an Agency is required to publish a general notice of rulemaking for any proposed or final rule, it must prepare and make available for public comment a regulatory flexibility analysis which describes the imapct of the rule on small entities (i.e., small businesses, small organizations, and small governmental jurisdictions). The Administrator may certify, however, that the rule will not have a significant economic impact on a substantial number of small entities.

This amendment will not have adverse economic impact on small entities since its effect will be to reduce the overall costs of EPA's hazardous waste regulations. Accordingly, I hereby certify that this final regulation will not have significant economic impact on a substantial number of small entities.

This regulation, therefore, does not require a regulatory flexibility analysis.

List of Subjects in 40 CFR Part 261

Hazardous waste, Recycling.

Dated: May 23, 1986.

Marcia Williams,

Director, Office of Solid Waste.

For the reasons set out in the preamble, 40 CFR Part 261 is proposed to be amended as follows:

PART 261—IDENTIFICATION AND LISTING OF HAZARDOUS WASTE

1. The authority citation for Part 261 continues to read as follows:

Authority: Secs. 1006, 2002(a), 3001, and 3002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976, as amended [42 U.S.C. 6905, 6912(a), 6921, and 6922].

§ 261.31 [Amended]

2. In § 261.31, add the following waste stream in numerical order:

EPA hazardous waste No.	Hazardous waste	Hazard code
•	• • • • •	
F031	Residues resulting from the incineration or thermal treatment of EPA Hazardous Waste Nos. F020, F021, F022, F023, F026, and F027, as identified in Appendix IX, Table 4.	(T)
•	• • • • •	

Appendix VII [Amended]

3. Add the following entry in numerical order to Appendix VII of Part 261:

EPA hazardous waste No.	Hazardous waste constituents for which listed
•	• • • • •
F031	Tetra-, penta-, and hexachlorodibenzo-p-dioxins; tetra-, penta-, and hexachlorodibenzofurans; tri-, tetra-, and pentachlorophenols and their chlorophenoxy derivatives.
•	• • • • •

4. In Appendix IX, add Table 4 and the following wastestream:

Appendix XI—Wastes Excluded Under §§ 260.20 and 260.22

TABLE 4.—WASTE REDESIGNATED FROM ACUTE HAZARDOUS WASTE TO HAZARDOUS WASTE

Facility	Address	Waste description
U.S. EPA Combustion Research Facility (CRF).	Jefferson, AR.	(1) Scrubber water generated by CRF's incineration of the "Vertac waste". (2) All future scrubber water generated by CRF's incinerator burning listed dioxin-containing waste contingent upon analyzing each tank of wastewater for the CDD/CDF homologs and that the TCDD equivalent is below 10 ppt.

[FR Doc. 86-12383 Filed 6-2-86; 8:45 am]

BILLING CODE 6560-50-M

1985 "residue rule" to designate all residues resulting from six 9's incineration of waste containing CDDs and CDFs as hazardous (T), rather than acute hazardous (H), based on a testing requirement for the residue.

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 86-199, RM-5258]

Radio Broadcasting Services; Broken Bow, OK

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein proposes the substitution of Channel 291C2 for Channel 292A at Broken Bow, Oklahoma, and the modification of Station KKBI-FM's license to specify operation on the higher powered channel, at the request of Harold E. Cochran.

In addition to filing comments with the FCC, interested parties should serve the petitioner, or their counsel or consultant, as follows: Vicent J. Curtis, Jr., Esq., Fletcher, Heald & Hildreth, 1225 Connecticut Avenue, NW., Suite 400, Washington, D.C. 20036 (Counsel to petitioner).

DATES: Comments must be filed on or before July 21, 1986, and reply comments on or before August 5, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Notice of Proposed Rule Making, MM Docket No. 86-199, adopted May 15, 1986, and released May 28, 1986. The full text of

this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW., Suite 140, Washington, DC 20037.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court reviews, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1231 for rules governing permissible *ex parte* contact.

For information regarding proper filing procedures for comments, See 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Radio Broadcasting

Federal Communications Commission.

Ralph Haller,

Acting Chief, Policy & Rules Division Mass Media Bureau.

[FR Doc. 86-12338 Filed 6-2-86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-200, RM-5239]

Radio Broadcasting Services; Lone Grove, OK

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein proposes the allocation of Channel 294A to Lone Grove, Oklahoma, as the community's first local FM service, at the request of SSS Communications, Inc.

In addition to filing comments with the FCC, interested parties should serve the petitioner, or their counsel or consultant, as follows: SSS Communications, Inc., Attn: Steve L. Sowers, 906 A Street, NW., Ardmore, Oklahoma 73401 (Petitioner).

DATES: Comments must be filed on or before July 21, 1986, and reply comments on or before August 5, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Notice of Proposed Rule Making, MM Docket No. 86-200, adopted May 15, 1986, and released May 28, 1986. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW, Washington, D.C. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW, Suite 140, Washington, D.C. 20037.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1231 for rules governing permissible *ex parte* contact.

For information regarding proper filing procedures for comments, See 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Federal Communications Commission.

Ralph Haller,

Acting Chief, Policy & Rules Division Mass Media Bureau.

[FR Doc. 86-12337 Filed 6-2-86; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 86-194, RM 5386]

Radio Broadcasting Services; Lampasas, TX

AGENCY: Federal Communications Commmission.

ACTION: Proposed rule.

SUMMARY: This document request comments on a petition by Ronald K. Witcher, licensee of FM Station KLTD (Channel 257A), Lampasas, Texas, proposing the substitution of Channel 256C1 for Channel 257A and modification of its license accordingly. The proposal could provide a first wide area coverage station at Lampasas.

In addition to filing comments with the FCC, interested parties should serve the petitioners, or their counsel or consultant, as follows: Ronald K. Witcher. c/o Bromo Communications, P.O. Box M, St. Simons Island, Georgia 31522.

DATES: Comments must be filed on or before July 14, 1986, and reply comments on or before July 29, 1986.

ADDRESS: Federal Communications Commission, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Notice of Proposed Rule Making, MM Docket No. 86-194, adopted May 12, 1986, and released May 23, 1986. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW, Washington, D.C. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW, Suite 140, Washington, DC 200378. .

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1231 for rule governing permissible *ex parte* contact.

For information regarding proper filing procedures for comments, See 47 CFR 1.415 and 1.420.

List of Subject in 47 CFR Part 73

Radio broadcasting.

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division Mass Media Bureau.

[FR Doc. 86-12339 Filed 6-2-86; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF DEFENSE

48 CFR Parts 230 and 253

Department of Defense Federal Acquisition Regulation Supplement; Cost Accounting Standards

AGENCY: Department of Defense (DoD)

ACTION: Proposed rule and request for comments.

SUMMARY: The Defense Acquisition Regulatory Council is considering a change to the coverage in the DoD FAR

Supplement to add the Cost Accounting Standards Disclosure Statement (253.303–70–DD–xxx) and to prescribe at 230.501–7 the form used to compute the Facilities Capital Cost of Money Factors (253.303–70–DD–x).

DATE: Comments on the proposed revisions should be submitted in writing to the Executive Secretary, DAR Council, at the address shown below on or before August 4, 1986, to be considered in the formulation of a final rule. Please cite DAR Case 85–139 in all correspondence related to this issue.

ADDRESS: Interested parties should written comments to: Defense Acquisition Regulatory Council, ATTN: Mr. Charles W. Lloyd, Executive Secretary, ODASD(P)/DARS, c/o OASD(A&L)(MRS), Room 3C841, The Pentagon, Washington, DC 20301–3062.

FOR FURTHER INFORMATION CONTACT: Mr. Charles W. Lloyd, Executive Secretary, DAR Council, (202)697–7266.

SUPPLEMENTARY INFORMATION:

A. Background.

Public Law 91–379 (50 U.S.C. APP. 2168) requires certain defense contractors and subcontractors to disclose in writing and follow consistently their cost accounting practices. In a document published elsewhere in this issue of the **Federal Register** the FAR Secretariat proposed changes to Federal Acquisition Regulation Part 30 to incorporate Cost Accounting Standards into the FAR. Although the Standards themselves are being considered for incorporation into the FAR, it is proposed that the Form CASB–DS–1, CASB Disclosure Statement, and the Form CASB–CMF, Facilities Capital Cost of Money Factors Computation, be changed to DoD forms with no planned change in format and be incorporated into the DoD FAR Supplement. Copies of the proposed forms may be obtained from the address cited above.

B. Regulatory Flexibility Act.

The proposed change to DoD FAR Supplement Part 230 will not have a significant impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 et seq.) because the changes cover Cost Accounting Standards and associated rules and regulations from which small business concerns are exempt.

C. Paperwork Reduction Act.

The collection of information is required by FAR 30.202 and 30.5. The forms being proposed by this coverage is nothing more than the vehicle used to collect the information and does not require an OMB clearance.

List of Subjects in 48 CFR Parts 230 and 253

Government procurement.

Owen L. Green

Acting Executive Secretary Defense Acquisition Regulatory Council.

Therefore, it is proposed that 48 CFR Parts 230 and 253 be amended as follows:

1. The authority citation for 48 CFR Part 230 and 253 continues to read as follows:

Authority: 5 U.S.C. 301, 10 U.S.C. 2202, DoD Directive 5000.35, and DoD FAR Supplement 201.301.

PART 230—COST ACCOUNTING STANDARDS

2. A new subpart 230.5, consiting of section 230.501–7, is added to read as follows:

Subpart 230.5—Cost of Money for Capital Employed for Facilities in Use or Under Construction

230.501–7 Contract Facilities Capital Estimates.

(a) After the appropriate DD Forms (x) have been analyzed and CMF's have been developed, the contracting officer is in a position to estimate the facilities capital cost of money and capital employed for a contract proposal. DD Form 1861, "Contract Facilities Capital and Cost of Money", have been provided for this purpose and, when properly completed, becomes a connecting link between the DD Forms (x) and DD Form 1547, "Weighted Guidelines Profit/Fee Objective". An evaluated contract cost breakdown, reduced to the contracting officer's prenegotiation cost objective, must be available. The procedure is similar to applying overhead rates to appropriate overhead allocation based to determine contract overhead costs.

(b) DD Form 1861 provides for listing overhead pools and direct-charging service centers (if used) in the same structure they appear on the contractor's cost proposal and DD Forms (x). The structure and allocation base units-of-measure must be compatible on all three displays. The base for each overhead pool must be broken down by year to match each separate DD From (x). Appropriate contract overhead allocation base data are extracted by year from the evaluated cost breakdown or prenegotiation cost objective, and are listed against each separate DD Form (x). Each allocation base is multiplied by its corresponding cost of money factor to get the Facilities Capital Cost of Money estimated to be incurred each year. The sum of these products represents the estimated Contract Facilities Capital Cost of Money for the year's effort. Total contract facilities cost of money is the sum of the yearly amounts.

(c) Since the Facilities Capital Cost of Money Factors reflect the applicable cost of money rate in Column 1 of DD Form (x), the Contract Facilities Capital Employed can be determined by *dividing* the contract Cost of Money by that same rate. DD Form 1861 is designed to record and compute all the above in the most direct way possible, and the end result is the Contract Facilities Capital Cost of Money and Capital Employed which is carried forward to DD Form 1547.

PART 253—FORMS

3. Section 253.230–70 is added to read as follows:

253.230–70 Cost Accounting Standards (DD Form X and XXX).

(a) *DD Form X, Facilities Capital Cost of Money Factor Computation (Rev. 1986).* DD Form X is used by contractors as the basis for measurement and allocation of facilities cost of money to indirect cost pools at the business unit level.

(b) *DD Form XXX, Cost Accounting Standards Disclosure Statement (Rev. 1986).* DD Form XXX is used by contractors to disclose cost accounting practices by providing a written description of their cost accounting practices and procedures.

[FR Doc. 86–12420 Filed 6–2–86; 8:45 am]
BILLING CODE 3810–01–M

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48 CFR Part 232

Department of Defense Federal Acquisition Regulation Supplement; Contract Financing

AGENCY: Department of Defense (DoD).

ACTION: Proposed rule and request for comments.

SUMMARY: The Defense Acquisition Regulatory Council is considering a change to the coverage in the DoD FAR Supplement at 232.501–1 to make the progress payment rates for Foreign Military Sales (FMS) Contracts the same level as provided by DoD on domestic defense contracts. This means that the progress payment rate would be 80% for other than small businesses and 90% for small businesses.

DATE: Comments on the proposed revisions should be submitted in writing to the Executive Secretary, DAR Council, at the address shown below on or before July 3, 1986, to be considered in the formulation of the final rule. Please cite DAR Case 86-52 in all correspondence related to this issue.

ADDRESS: Interested parties should submit written comments to: Defense Acquisition Regulatory Council, Attn: Mr. Charles W. Lloyd, Executive Secretary, ODASD(P)DARS, c/o OASD(A&L)(MRS), Room 3C841, The Pentagon, Washington, DC 20301-3062.

FOR FURTHER INFORMATION CONTACT: Mr. Charles W. Lloyd, Executive Secretary, DAR Council, telephone (202)697-7266.

SUPPLEMENTARY INFORMATION:

A. Background.

These changes are being considered in a response to a recommendation contained in DoD Defense Financial and Investment Review (DFAIR). DFAIR had concluded that the working capital requirements on FMS contracts were higher than experienced on domestic defense contracts. Thus the progress payment rates should not be different.

B. Regulatory Flexibility Act.

It is expected that the proposed change to DFARS 232.501-1(a) will have little if any impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 et seq.). A Regulatory Flexibility Analysis has been prepared and submitted to the Chief Council for Advocacy for the Small Business Administration.

C. Paperwork Reduction Act.

The proposed rule does not contain information collection requirements which require the approval of OMB under 44 U.S.C. 3501 et seq.

List of Subjects in 48 CFR Part 232

Government procurement.

Owen L. Green,

Assistant to the Executive Secretary, Defense Acquisition Regulatory Council.

Therefore, it is proposed that 48 CFR Part 232 be amended as follows:

PART 232—CONTRACT FINANCING

1. The authority citation for 48 CFR Part 232 continues to read as follows:

Authority: 5 U.S.C. 301, 10 U.S.C. 2202, DoD Directive 5000.35, and DoD FAR Supplement 201.301.

§ 232.501-1 [Amended]

2. Section 232.501-1 is amended by revising paragraph (a) to read as follows:

232.501-1 Customary Progress Payment Rates.

(a) The customary progress payment rate applicable to Foreign Military Sales requirements is the same as that applicable to DoD requirements. The customary progress payment rate for flexible progress payments is the rate determined by use of either the CASH II or CASH III computer program as applicable in accordance with the requirements of 232.502-1(S-71).

* * * * *

[FR Doc. 86-12419 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-01-M

DEPARTMENT OF TRANSPORTATION

Research and Special Programs Administration

49 CFR Parts 171, 172, 173, 174, 176, 177, 178, and 179

[Docket No. HM-166U; Notice No. 86-3]

Transportation of Hazardous Materials; Proposed Miscellaneous Amendments

AGENCY: Research and Special Programs Administration (RSPA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Research and Special Programs Administration is proposing to make several miscellaneous amendments to the regulations pertaining to the transportation of hazardous materials. The action is necessary to update the regulations and to reduce RSPA's backlog of rulemaking petitions.

DATES: Comments must be received by July 31, 1986.

ADDRESS: Address comments to the Dockets Branch, Research and Special Programs Administration, U.S. Department of Transportation, Washington, DC 20590. Comments should identify the docket and notice number and be submitted in five copies. Persons wishing to receive confirmation of receipt of their comments should include a self-addressed stamped post card. The Dockets Branch is located in Room 8426 of the Nassif Building, 400 7th Street SW., Washington, DC. Public dockets may be reviewed between the hours of 8:30 a.m. and 5:00 p.m. Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Darrell L. Raines, Chief, Exemptions and Regulations Termination Branch, Office of Hazardous Materials Transportation, Washington, DC 20590 (202) 426-2075.

SUPPLEMENTARY INFORMATION: This document is primarily designed to reduce regulatory burdens by incorporating changes in the Hazardous Materials Regulations based on either petitions for rulemaking submitted in accordance with 49 CFR 106.31 or on RSPA's own initiative. These proposed amendments are in keeping with Executive Order 12291 and are designed to simplify existing regulations.

In Part 171, these proposed amendments would (1) update five Compressed Gas Association Pamphlets to the latest editions; (2) update the Association of American Railroads "Specifications for Tank Cars" to the 1985 edition; (3) incorporate by reference ASTM D 4359-84 "Standard Test Method for Determining Whether a Material is a Liquid or a Solid"; and (4) add a definition for "Liquid" and "Solid".

In Part 172, the Table would be revised by (1) removing the entries "1-Bromo-3-nitrobenzene (unstable at 56 °C)" and "Compound, water treatment, liquid. *See* Water treatment, liquid."; (2) reinstating the entry "Ethyl phosphonothioicdichloride, anhydrous"; (3) changing the ID number for the entry "Ink", combustible liquid; (4) changing the hazard class for the entry "Ethylene glycol diethyl ether (diethyl cellosolve)"; (5) revising the entry "Gasohol (*gasoline mixed with ethyl alcohol*). *See* Gasoline"; (6) adding a new entry "Air, refrigerated liquid (*cryogenic liquid*)"; (7) changing the hazard class, label, and packaging authorization sections for ethylene dibromide. This change results from RSPA's review of published data that indicates the proper hazard class for this material should be "Poison B" instead of "ORM-A". The toxicity of this material is such that it poses a significant hazard to health during transportation. This change in classification and packaging authorization would result in this material being subject to the requirements of §173.3a; and (8) adding "Aluminum alkyl" and "Aluminum alkyl halide" to the § 172.102 Table. In § 172.202, paragraph (a)(4) would be revised to require the unit of measure to be identified on the shipping papers. In § 172.336, paragraphs (c)(4) and (c)(5) would be revised by adding the word "petroleum" before the word "distillate". In § 172.504, footnote 8 of Table 2 would be amended to include an OXYGEN placard. In § 172.519, paragraphs (b)(2) and (b)(4) would be revised to upgrade the placard construction standards.

In Part 173, these proposed amendments would (1) amend § 173.11(b)(4) to require the registration statement to include the type of packaging being used; (2) amend Retest Table 2 in § 173.31 to include DOT Specification 110A600–W multi-unit tank cars; (3) revise § 173.32 to authorize a portable tank to be used as a cargo tank; (4) revise § 173.51(g) to provide an exception for persons who are authorized to board an airplane with a loaded firearm; (5) remove paragraph (b) in § 173.57; (6) make an editorial correction in § 173.81(b) and § 173.104(c) regarding the marking for detonating cord; (7) add a paragraph (h) and (i) in § 173.86 regarding small arms ammunition and devices which contain small quantities of explosives; (8) amend the introductory text of § 173.87 to reference § 173.7(a); (9) add paragraph (a)(2) in § 173.93 to authorize smokeless powder for small arms to be shipped as Class B explosives in packagings approved in accordance with § 173.197a; (10) make an editorial correction in § 173.104; (11) remove paragraph (a)(4) in § 173.122; (12) amend § 173.164(a)(2) to add DOT Specification 17C metal drums for packaging chromic acid or chromic acid mixture, dry; (13) revise § 173.197a by adding the Bureau of Mines and to authorize co-mingling of inside boxes of smokeless powder for small arms; (14) amend the introductory text of § 173.220(a) to authorize the use of fiberboard boxes with inside polyethylene bags for packaging magnesium or zirconium scrap consisting to borings, shavings, or turnings; (15) add a Note 2 in § 173.245(a) to amend the requirements for nickel tank car tanks and cargo tanks for consistency with fabricating capabilities and construction materials available in the market place today. Similiar changes are being proposed in § 173.253(a)(7) and (8), § 173.271(a)(7), (8) and (9), § 173.294(a)(2), (3), and (b), § 179.202–8, § 179.202–11, and § 179.202–16; (16) to provide for marking of stainless steel cargo tanks; (17) remove paragraph (d)(1) in § 173.277; (18) amend the first sentence of § 173.300(a) to clarify that a cryogenic liquid is subject to regulation without regard to the pressure in the package; (19) revise § 173.301(k) to remove the requirement that the outside packaging must provide value protection if the cylinder has features providing valve protection; (20) revise § 173.302(a)(5)(iv) by restricting the charged service pressure for oxygen to 3000 psig at 70°; (21) reinstate DOT 4BW225 for sulfur dioxide in § 173.304(a)(2); (22) revise Note 6 in § 173.314 to make the safety relief devices to be the same as required in § 179.102–1(a)(3); (23) make an editorial correction in § 173.315(c); (24) amend § 173.316(c)(2) to provide filling limits for "air refrigerated liquid (*cryogenic liquid*)" in cylinders; (25) revise § 173.318(b)(2)(i)(B), (iii), and (iv) to require the use of a primary and a secondary system of pressure relief devices on cargo tanks used in cryogenic liquid service; (26) amend § 173.318(f) (2) and (3) to provide filling limits for "air, refrigerated liquid" and "hydrogen, refrigerated, liquid" in cargo tanks"; (27) add a new paragraph (a)(3) in § 173.320 to include a reference to Subparts A and B of Part 173, § 174.1 and § 177.804; and (28) reinstate § 173.965 "Cotton and other fibers".

In Part 174, these proposed amendments would amend § 174.9(b) by changing the word "must" to "may" regarding the drainage of heater coil inlet and outlet pipes.

In Part 176, § 176.76(g)(2) would allow hazardous materials in portable tanks to be transported on small passenger vessels.

In Part 177, these proposed amendments would remove paragraph (k) of § 177.834 which specifies how certain hazardous materials must be loaded to provide ready access, (2) revise § 177.841(e) to prohibit a motor carrier from carrying poisons in the passenger compartment of a motor vehicle and (3) revise § 177.848(b) to authorize cyanides or cyanide mixtures to be loaded or stored with corrosive liquids that are alkaline.

In Part 178, these proposed amendments would (1) authorize DOT–3E cylinders to be stamped in the sidewall; (2) correct and update the DOT–3AL Specification in § 178.46; (3) revise § 178.51–10(d) and § 178.61–10(b) regarding wall thickness of DOT Specifications 4BA and 4BW steel cylinders (4) make an editorial correction in § 178.53–9(a) regarding DOT–4D cylinders; (5) remove DOT–4B240–FLW from Part 178 and (6) revise § 178.245–1(a) by removing the requirement that DOT Specification 51 portable tanks must be postweld heat treated.

In Part 179, several of these proposed miscellaneous changes are based on recommendations from the Association of American Railroads and are designed to update and clarify the present wording. The Chlorine Institute requested that § 179.102–2(a)(3) be revised to allow the use of a new insulation package of future tank cars for chlorine.

I certify that this proposed regulation will not, if promulgated, have a significant economic impact on a substantial number of small entities. Also, the RSPA has determined that this Notice (1) is not "major" under Executive Order 12291; (2) is not "significant" under DOT Regulatory Policies and Procedures (44 FR 11034: February 26, 1979); (3) does not warrant preparation of a regulatory evaluation as the anticipated impact would be so minimal; (4) will not affect not-for-profit enterprises, or small governmental jurisdictions and (5) does not require an environmental impact statement under the National Environmental Policy Act (49 U.S.C. 4321 et seq.).

The following list of Federal Register Thesaurus of Indexing Terms apply to this notice of proposed rulemaking:

List of Subjects

49 CFR Part 171

Hazardous materials transportation, Definitions.

49 CFR Part 172

Hazardous materials transportation, Labeling, packaging and containers.

49 CFR Part 173

Hazardous materials transportation, Packaging and containers.

49 CFR Part 174

Hazardous materials transportation, Railroad safety.

49 CFR Part 176

Hazardous materials transportation, Maritime, carriers, Radioactive materials.

49 CFR Part 177

Hazardous materials transportation, Motor carriers.

49 CFR Part 178

Hazardous materials transportation, Packaging and containers.

49 CFR Part 179

Hazardous materials transportation, Railroad safety.

Regulation affected	Reason(s) for proposed change,	Proposed amendment
§ 171.7(d)(2)	To reference the latest edition of the AAR's "Specification for Tank Cars."	In § 171.7, paragraph (d)(2) would be revised to read as follows: (2) AAR Specifications for Tank Cars means the 1985 edition of the "Association of American Railroads Specifications for Tank Cars, Specification M-1002."
§ 171.7(d)(3)(ii)	To update CGA Pamphet C-6 to the 1984 edition	In § 171.7 paragraph (d)(3)(ii) would be revised to read: (ii) CGA Pamphlet C-6 is titled "Standards for Visual Inspection of Steel Compressed Gas Cylinders", 1984 edition.
§ 171.7(d)(3)(iii)	To update CGA Pamphlet C-7 to the 1983 edition	In § 171.7, paragraph (d)(3)(ii) would be revised to read: (iii) CGA Pamphlet C-7, Appendix A, is titled "Guide to the Preparation of Precautionary Labeling and Marking of Compressed Gas Containers",1983 edition.
§ 171.7(d)(3)(iv)	To update CGA Pamplet C-8 to the 1985 edition	In § 171.7, paragraph (d)(3)(iv) would be revised to read: (iv) CGA Pamphlet C-8 is titled, "Standard for Requalification of DOT-3HT Cylinders", 1985 edition.
§ 171.7(d)(3)(ix)	To update CGA Pamphlet G-4.1 to the 1985 edition	In § 171.7, paragraph (d)(3)(ix) would be amended by changing "1977" edition to read "1985" edition.
§ 171.7(d)(3)(x)	To incorporate CGA Pamphlet G-2.2, 1985 edition, referenced in § 173.315(1)(5)	In § 171.7, paragraph (d)(3)(x) would be added to read: (x) CGA Pamphlet G-2.2 is titled, "Guideline Method for Determining Minimum of 0.2% Water in Anhydrous Ammonia", 1985 edition.
§ 171.7(d)(5)	To incorporate by reference ASTM D 4359-84 "Standard Test Method for Determining Whether a Material is a Liquid or a Solid". Also, in § 171.8 definitions for "Liquid" and "Solid" would be added.	In § 171.7, paragraph (d)(5) (xxdv) would be added to read as follows: (xxdv) ASTM D 4359-84 is titled "Standard Test Method for Determining Whether a Material is a Liquid or a Solid", 1984 edition.
§ 171.8	To add a definition for "Liquid" and "Solid" as tested in accordance with ASTM D 4359-84.	In § 171.8, definitions for "Liquid" and Solid" would be added to read as follows: "Liquid" means a material that has a vertical flow over 2 inches (50 mm) within a three minute period, or a material having one gram (lg) or more liquid separation when determined in accordance with the procedures specified in ASTM D 4259-84, "Standard Test Method for Determining Whether a Material is a Liquid or Solid", 1984 edition. • • • • • • "Solid" means a material which has a vertical flow of two inches (50 mm), or less, within a three-minute period, or; a separation of one gram (lg), or less, of liquid when determined in accordance with the procedures specified in ASTM D 4359-84 "Standard Test Method for Determining whether a material is a Liquid or Solid", 1984 edition.
§ 172.101(Table)	The American Hoechst Corporation has requested that the entry "1-Bromo-3-nitrobenzene (unstable at 56 °C.)" be removed as a "Forbidden" material. Based upon the information received and upon further research, the RSPA agrees that this material is not chemically unstable and should not be listed as a forbidden material.	In the § 172.101 Table the entry "*1-Bromo-3-nitrobenene (unstable at 56°C)*" would be removed.
§ 172.101 (Table)	The Ethyle Corporation has brought to our attention that the entire Table entry for "Ethyl Phosphonothioicdichoride, anhydrous" does not appear in the latest edition of 49 CFR. It appears that this entry was inadvertently removed when a change was made to the entry "Ethyl phosphonus dichloride, anhydrous".	In the § 172.101 Table the entire entry for "ethyl phosphonothioicdichloride, anhydrous" would be reinstated the same as it appeared in the October 1, 1982 edition of 49 CFR.
§ 172.101 (Table)	The entry "Compound, water treatment, liquid. *See* Water treatment, liquid" should be removed. The entry "Water treatment liquid" was removed under Docket HM-166-0 on November 17, 1983, [48 FR 52306]. However, the entry "Compound, water treatment, liquid. *See* Water treatment, liquid" was omitted.	In § 172.101, the Table would be amended by removing the entry "Compound, water treatment, liquid. *See* Water treatment, liquid."
§ 172.101 (Table)	To change the ID number for "Ink", combustible liquid, from UN 2867 to UN 1210 to be consistent with the entry in the United Nations Recommendations for the Transport of Dangerous Goods.	In § 172.101, the Table would be amended by changing the ID number for "Ink", combustible liquid, from UN 2867 to read UN 1210.
§ 172.101 (Table)	The entry "Ethlene dibromide" is presently classed as an "ORM-A". RSPA has found published date that indicates that the proper hazard class for this material should be Poison B instead of ORM-A.The toxicity of this material is such that it may pose a significant hazard to health during transportation.	In § 172.101, the Table would be amended by changing the hazard class of "ethylene dibromide" from "ORM-.A" to Posion B; the label would be changed from "None" to "Poison"; the packaging columns would be changed from "173.505 and 173.620" to "173.345 and 173.346" respectively.
§ 172.101 (Table)	The entry "Ethylene glycol diethyl ethe (diethyl cellosolve)" is presently classed as a "Combustible liquid". The Grant Chemical Division has furnished us data that indicates that the proper hazard class for this material should be flammable liquid instead of combustible liquid..	In § 172.101, the Table would be amended by changing the hazard class for "Ethylene glycol diethyl either (diethyl cellosolve)" from "Combustible liquid" to "Flammable liquid".
§ 172.101(Table)	This change is considered necessary to correctly identify the proper Emergency Reponse Guide number for Gasohol which has a maximum alcohol content of 20 percent. Paragraphs (c)(4) and (c)(5) in § 172.336 would be revised accordingly.	In the § 172.101 Table, the entry "Gasohol (*gasoline mixed with ethyl alcohol*). *See* Gasoline" would be revised to read "Gasohol (*gasoline mixed with ethyl alcohol containing 20% maximum alcohol*)." *See* Gasoline. In § 172.336, paragraphs(c)(4) and (c)(5) would be revised to read as follows: (4) For each of the different liquid petroleum distillate fuels, including gasoline and gasohol in a compartmented cargo tank or tank car, if the identification number is displayed for the distillate fuel having the lowest flash point. (5) For each of the different liquid petroleum distillate fuels, including gasoline and gasohol transported in a cargo tank, if the identification number is displayed for the liquid petroleum distillate fuel having the lowest flash point.
§ 172.102)Table)	The entries "Aluminum alkyl, UN3051"and "Aluminum alkyl halide, UN3052" would be added in order to comply with Amendment 22-84 of the IMDG Code which becomes effective July 1, 1986. These changes are necessary to avoid the need for dual shipping names and placarding for certain pyroforic liquids.	In § 172.101, the table would be amended by adding "Aluminum alkyl" and "Aluminum alkyl halide".

§ 172.101 Hazardous Materials Table.

+/E/A/W	Hazardous materials descriptions and proper shipping names	Hazard class	Identification number	Label(s) required (if not excepted)	Packaging		Maximum net quantity in one package		Water shipments		
					Exceptions	Specific requirements	Passenger carrying aircraft or railcar	Cargo only aircraft	Cargo vessel	Passenger vessel	Other requirements
(1)	(2)	(3)	(3)(a)	(4)	(5)(a)	(5)(c)	(6)(a)	(6)(b)	(7)(a)	(7)(b)	(7)(c)
	ADD										
	Air, refrigerated liquid (*cryogenic liquid*).	Nonflammable Gas.	UN 1003	Nonflammable Gas.	173.320	173.316, 173.318	Forbidden	300 pounds	1,3	1,3	Stow separate from flammables. Do not overstow with other cargo.

Regulation affected	Reason(s) for proposed change	Proposed amendment
§ 172.202(a)(4)	To require the unit of measure to be identified on the shipping papers	In § 172.202, paragraph (a)(4) would be revised to read as follows: (4) Except for empty packagings, cylinders for compressed gases, and packagings of greater than 110 gallons capacity, the total quantity by weight (net or gross as appropriate) or volume, including the unit of measure, of the hazardous material covered by the description. For example: "800 lbs."; "55 gal.".
§ 172.504 Table 2	To eliminate the need for dual placarding	In § 172.504, footnote 8 of Table 2 would be amended by adding" or an OXYGEN placard" at the end.
§ 172.519(b)(2) and (4).	Proposed change responds to a petition of National Tank Truck Carriers, Inc., (P-963) concerning the need to upgrade the placard construction standards. Some of the present placards being employed do not have sufficient durability to withstand weathering for 30 days consistent with the intent of the present § 172.519(a)(4).	In § 172.519, paragraphs (b)(2) and (b)(4) would be revised to read as follows: (2) A weight of 200 pounds per ream of 24 by 36-inch sheets; (4) Been treated with plastic or other waterproofing material that will give it the ability to withstand open weather exposure (including rain) for 30 days without a substantial reduction in effectiveness.
§ 173.11(b)(4)	To require that a shipper identify the type of packaging being used to ship a flammable cryogenic liquid on the registration statement.	In § 173.11, the beginning of the first sentence of paragraph (b)(4) would be amended as follows: (4) The type of packaging and the serial number or vehicle identification number • • •
§ 173.31 Retest Table 2.	To amend Retest Table 2 to include a new DOT Specification 110A600–W multi-unit tank car tank that is being added to § 1790.301.	In § 173.31, Retest Table 2 would be amended by adding the following:

RETEST TABLE 2

Specification	Retest interval—years		Retest pressure p.s.i.		Safety relief valve pressure—p.s.i.	
	Tank	Safety relief devices	Tank hydrostatic expansion	Tank air test	Start-to-discharge	Vapor tight
• • • • • • •	•	•	•	•		
110A600–W	5	2	600	100	450	360
• • • • • • •	•	•	•	•		

Regulation affected	Reason(s) for proposed change	Proposed amendment
§ 173.32(a)	To provide for the use under certain conditions of a portable tank as a cargo tank	In § 173.32, paragraph (a)(1) would be revised and a new paragraph (a)(2) would be added to read as follows: (a) • • • (1) A portable tank containing a hazardous material may not be transported on a motor vehicle unless it is secured to the motor vehicle by a system which conforms to the requirements contained in 49 CFR 393.100 through 393.106, and is located at least six inches forwarded of the motor vehicle's rear bumper. A portable tank may not be filled or discharged while the tank remains on the vehicle, except as provided by paragraph (a)(2) of this section. (2) A DOT Specification 51, 60 or Marine Portable Tank (46 CFR Part 64) or an equivalent non-DOT specification portable tank authorized under a DOT exemption may not be filled or discharged while the tank remains on the motor vehicle, unless— (i) each discharge and filling outlet is equipped with an internal valve. Additionally, tanks used for the transportation of liquefied compressed gases, except carbon dioxide, must be equipped with excess-flow valves as specified in paragraph (n) of this section; (ii) botton outlets, if provived, are fitted with three serially-mounted closures consisting of an internal valve, an external valve and a bolted flange or other suitable, liquid-tight closure on the outlet side of the external valve, and (iii) the internal valve is fitted with a remote means of closure located more than 10 feet from the loading/unloading-hose connection or as far as possible from the loading/unloading-hose connection. The remote closure system must be corrosion resistant and effective in all environments. The remote means of closure must be actuated manually. For other that corrosive material service, the remote means of closure must also be activated thermally. Thermally activated closures must operate at a temperature not over 250°F. and not less than 230°F.
§ 173.32c	See § 173.32(a)	In § 173.32c new paragraphs (m)(1) and (2) would be added to read as follows: (m)(1) An IM portable tank containing a hazardous material may not be transported on a motor vehicle unless it is secured to the motor vehicle by a system which conforms to the requirements of 49 CFR 393.100 through 393.106 and is located at least six inches forward of the motor vehicle's rear bumper. (2) A Specification IM 101 and IM 102 portable tank may not be filled or discharged while the tank remains on the motor vehicle, unless the portable tank—

Regulation affected	Reason(s) for proposed change	Proposed amendment
		(i) is in conformance with the requriements of paragraph (g) of this section; and (ii) when required, the internal valve is fitted with a remote means of closure located more than 10 feet from the loading/unloading-hose connection or as far as possible from the loading/unloading-hose connection. The remote closure system must be corrosion resistant and effective in all environments. The remote means of closure must be actuated manually. For other than corrosive material service, the remote means of closure must also be activated thermally. Thermally activated closures must operate at a temperature not over 250°F. and not less than 230°F.
§ 173.51	In 14 CFR 108.11 certain persons are authorized to board an airplane with a loaded weapon. In § 173.51, paragraph (g) prohibits the transportation of loaded firearms. The RSPA is proposing to amend paragraph (g) of § 173.51 to provide for an exception as authorized in 14 CFR 108.11.	In § 173.51, paragraph (g) would be revised to read as follows: (g) Loaded firearms (except as provided in 14 CFR 108.11).
§ 173.57(b)	Column (2) of the § 172.101 Table specifies the hazardous materials descriptions and proper shipping names. Repeating this same information on Part 173 serves no useful purpose.	In § 173.57, paragraph (b) would be removed.
§ 173.81(b)	Editorial correction	In § 173.81, paragraph (c)(e) would be corrected to read (c)(3) and paragraph (b) would be revised to read as follows: § 173.81 *Detonating cord.* (a) * * * (b) Each outside packaging shall be plainly marked "CORD, DETONATING—HANDLE CAREFULLY".
§ 173.86(h) and (i).	This proposed change is considered necessary because this type of small arms ammunition has a low level of risk and the actual explosive components have been approved previously and separately from the ammunition itself.. Paragraph (i) is considered necessary to provide a means for recognizing that certain devices which contain explosives in small quantities or in certain configurations may be included in a different classification, or excepted from the requirements of the regulations..	In § 173.86, paragraphs (h) and (i) would be added to read as follows: § 173.86 *New explosives definitions; approval and notification.* * * * * * * * (h) The requirements of this section do not apply to small arms ammunition which is: (1) Not a forbidden explosive under § 173.51; (2) Ammunition for rifle, pistol, or shotgun; (3) Ammunition with inert projectiles or blank ammunition; and (4) Ammunition not exceeding 50 caliber for rifle or pistol cartridges or 8 gauge for shotshells. (i) If experience or other data indicate that the hazard of a material (device) containing an explosive composition is greater or less than indicated according to the definition and criteria specified in §§ 173.53, 173.88 and 173.100 of this Part, the Director, OHMT may, following examination in accordance with paragraph (b) of this section, revise its classification or except the material (device) from the requirements of this Subchapter.
§ 173.87	To authorize shipment of explosives and other articles when packaged by the Department of Defense (DOD) in accordance with § 173.7(a).	In § 173.87, the first sentence is amended to read as follows: § 173.87 *Explosives in mixed packaging.* Unless specifically authorized in this subchapter, explosives may not be packed in the same outside packaging with other articles unless packaged by the DOD in accordance with § 173.7(a). * * *
§ 173.93(a)(2)	To authorize smokeless powder for small arms to be shipped as Class B explosives in packagings which have been approved under § 173.97a.	In § 173.93, paragraph (a)(2) would be added to read as follows: § 173.93 *Propellant explosives (solid) for cannon, small arms, rockets, guided missiles, or other devices, and propellant explosives (liquid).* (a) * * * (1) * * * (2) Smokeless powdr for small arms may be shipped as Class B explosives in packagings approved in accordance with § 173.197a.
§ 173.104(c)	Editorial correction	In § 173.104, the heading and paragraph (c) would be revised to read as follows: § 173.104 *Cord, detonating flexible; fuse, mild detonating, metal clad; or flexible linear shaped charge, metal clad.* * * * * * * * (c) Cord, detonating flexible; fuse, mild detonating, metal clad and flexible linear shaped charges, metal clad shall be packed in wooden or fiberboard boxes. Each package shall be marked "CORD, DETONATING—HANDLE CAREFULLY", "FUSE, MILD DETONATING, METAL CLAD—HANDLE CAREFULLY" or "FLEXIBLE LINEAR SHAPED CHARGES, METAL CLAD—HANDLE CAREFULLY", as appropriate.
§ 173.122(a)(4)	To prohibit the use of DOT Specification 17C metal drums for packaging acrolein, inhibited. In view of HM-196, the use of the 17C drum should not be authorized for acrolein, inhibited.	In § 173.122, paragraph (a)(4) would be removed and reserved.
§ 173.164(a)(2)	This paragraph presently authorizes chromic acid or chromic acid mixture, dry, to be packaged in DOT Specification 17H or 37A metal drums. The U.S. Army Chemical Research and Development Center has requested that DOT Specification 17C steel drums be added to this paragraph. RSPA's findings indicates that DOT Specification 17C drums would be acceptable for this material.	In § 173.164, paragraph (a)(2) would be amended to include Specification 17C metal drums.
§ 173.197a	To authorize co-mingling of inside boxes of smokeless powder without further approval by the Director, OHMT. Also, the Bureau of Mines would be added as an authorized testing facility.	§ 173.197a *Smokeless powder for small arms.* Smokeless powder for small arms in quantities not exceeding 100 pounds net weight transported in one car or motor vehicle may be classed as a flammable solid when examined for this classification by the Bureau of Explosives or the Bureau of Mines and approved by the Director, OHMT. Maximum quantity in any inside packaging must not exceed 8 pounds and inside packagings must be arranged and protected to prevent simultaneous ignition of the contents. The complete package must be a type examined by the Bureau of Explosives or the Bureau of Mines and approved by the Director, OHMT. In addition, inside packages which have been examined by the Bureau of Explosives or the Bureau of Mines and approved by the Director, OHMT, may be overpacked in DOT-12A65, 12B65, or 12H65 fiberboard boxes provided all inside containers are firmly packed to prevent movement and the net weight of smokeless powder in any one box does not exceed 16 pounds. Each outside package must bear a flammable solid label.
§ 173 220(a)	To authorize the use of fiberboard boxes with inside polyethylene bags for packaging magnesium or zirconium scrap consisting of borings, shavings, or turnings. This proposed packagings is considered to be equal to or better than the four-ply paper bags that are presently authorized. Also, a paragraph (3) would be added to be consistent with the IMDG Code.	In § 173.220, the introductory text of paragraph (a) would be revised and paragraph (3) would be added to read as follows: (a) Magnesium or zirconium scrap consisting of borings, shavings, or turnings, must be packed in closed metal barrels or drums, wooden barrels, metal pails, fiber drums, fiberboard boxes with inside polyethylene bags or liner, or four-ply paper bags.

Regulation affected	Reason(s) for proposed change	Proposed amendment
		Fiberboard boxes with inside polyethylene bags or liner or paper bags are not authorized for less-than-carload or less-than-truckload shipments. • • • • • • (3) When transported by vessel, magnesium scrap may not be carried in paper bags and zirconium scrap may only be packaged in an hermetically sealed metal drum not exceeding 80 pounds net weight.
§ 173.245(a), Note 2.	These proposed changes and additions would amend the requirements for nickel tank car tanks and cargo tanks for consistency with fabricating capabilities and construction materials available in the market place today.	In § 173.245(a), Note 2 would be added to read as follows: § 173.245 *Corrosive liquids not specifically provided for.* (a) • • • (33) • • • Note 1: • • • NOTE 2. Specification 103ANW tank car tanks must be fabricated of solid nickel at least 95 percent pure and containing not more than 1 percent iron. Metal text coupons for welding procedure qualification must contain not more than 1 percent iron. All cast metal parts of the tank in contact with the lading must have a minimum nickel content of approximately 96.7 percent. Specification 103A tank car tanks must be lead-lined steel or must be made of steel with at least 10 percent nickel cladding. Specification 103AW, 111A100F2, or 111A60W2 tanks must be lead-lined steel or made of steel with a minimum nickel cladding of ⅛ inch thickness; nickel cladding in tanks must have a minimum nickel content of at least 99 percent. • • • • • •
§ 173.253(a)(7) and (8).	See § 173.245(a), Note 2	In § 173.253, paragraph (a)(7) and (a)(8) would be revised to read as follows: § 173.253 *Chloroacetyl chloride.* (a) • • • (7) Specification 103AW, 111A60W2, or 111A100F2 (§§ 179.200, 179.201 of this subchapter). Tank cars. Tanks must have a nickel cladding of 1/16 inch minimum thickness. Nickel cladding in tanks must have a minimum nickel content of at least 99 percent. (8) Specification 103ANW (§§ 179.200 and 179.201 of this subchapter). Tank cars. Tanks must be fabricated of solid nickel at least 95 percent pure and containing not more than 1 percent iron. Metal test coupons for welding procedure qualification must contain not more than 1 percent iron. All cast metal parts of the tank in contact with the lading must have a minimum nickel content of approximately 96.7 percent. • • • • • •
§ 173.266(f)(2)	To provide for the metal identification plate on stainless steel cargo tanks to be marked "DOT MC 312-SS-H_2O_2".	In § 172.266, the eighth sentence in paragraph (f)(2) would be revised to read as follows: § 173.266 *Hydrogen peroxide solution in water.* • • • • • • (f) • • • (2) • • • The tank metal identification plate required shall be marked "DOT MC 310-H_2O_2" or "DOT MC 312-AL-H_2O_2", or "DOT MC 312-SS-H_2O_2", as appropriate, and, in addition, the cargo tank shall be clearly marked in letters not less than one inch high "FOR HYDROGEN PEROXIDE ONLY". • • •
§ 173.271(a)(7), (a)(8)(iv), and (a)(9).	See § 173.245(a) Note 2	In § 173.271, paragraphs (a)(7), (a)(8)(iv), and (a)(9) would be revised to read as follows: § 173.271 *Methyl phosphonic dichloride, phosphorus oxybromide, phosphorus oxychloride, phosphorus trichloride, and thiophosphoryl chloride.* (a) • • • (7) Specification 103ANW (§§ 179.200 and 179.201 of this chapter). Tank cars. Tanks must be fabricated of solid nickel at least 95 percent pure and containing not more than 1 percent iron. Metal test coupons for welding procedure qualification must contain not more than 1 percent iron. All cast metal parts of the tank in contact with the lading must have a minimum nickel content of approximately 96.7 percent. (8) • • • • • • • • • (iv) Specification MC 311 or MC 312 cargo tanks. Tanks must be fabricated of solid nickel at least 95 percent pure and not more than 1 percent iron. Metal test coupons for welding procedure qualification must contain not more than 1 percent iron. All cast metal parts of the tank in contact with the lading must have a minimum nickel content of aproximately 96.7 percent. Authorized only for phosphorus oxychloride and phosphorus trichloride. (9) Specification 103A[1], 103AW, 111A60W2, or 111A100F2 (§§ 179.200, 179.201 of this subchapter). Tank cars. Specification 103A[1], tanks must be lead-lined steel or made of steel with nickel cladding of at least 10% of the shell thickness. Specification 1103AW, 111A60W2, or 111A100F2 tanks must be lead-lined steel or made of steel with nickel cladding with a minimum thickness of 1/16-inch. Nickel cladding in tanks must have a minimum nickel content of at least 99 percent. • • • • • •
§ 173.277(d)(1)	the RSPA proposed to delete paragraph (d)(1) of § 173.277. This paragraph should have been deleted when paragraph (d) was revised under Docket No. HM-103; HM-112 (41 FR 15972) on April 15, 1976.	In § 173.277, paragraph (d)(1) would be removed.
§ 173.294(a)(2), (a)(3) and (b).	See § 173.245(a) Note 2	In § 173.294, the heading, paragraphs (a)(2), (a)(3) and and (b) would be revised to read as follows: § 173.294 *Chloroacetic acid, liquid or solution.* (a) • • • (2) Specification 103ANW, 103AW, 111A60W2, or 111A100F2 (§§ 179.200, 179.201 of this subchapter). Tank cars. Specification 103AW, 111A60W2, or 111A100F2 tank cars must be nickel clad with a nickel thickness of at least 20 percent. Nickel cladding in tanks must have a minimum nickel content of at least 99 percent. (3) Specifications MC 310, MC 311, or MC 312 (§§ 178.343 of this chapter). Cargo tanks. Tanks must be fabricated of solid nickel at least 95 percent pure and containing not more than 1 percent iron, type 304 or 316 stainless steel or be suitably lined. Nickel metal test coupons for welding procedure qualification must contain not more than 1 percent iron. • • • • • •

Regulation affected	Reason(s) for proposed change	Proposed amendment
		(b) Chloroacetic acid, anhydrous, when shipped as a liquid must be shipped in Specification 103 ANW tank car tanks fabricated of nickel containing not more than 1 percent iron or in Specification 103 AW or 111A60W2 tank car tanks nickel clad. Cladding must be at least 20 percent of the shell thickness. In place of cladding, the tank may be provided with a suitable corrosive resistant coating or lining. Nickel cladding in tanks must have a minimum nickel content of a least 99 percent.
§ 173.300(a)	To clarify that a cryogenic liquid is subject to regulation without regard to the pressure in the container.	In § 173.300, a sentence would be added at the end of paragraph (a) to read as follows: (a) * * *, or a cryogenic liquid. For a definition of a cryogenic liquid, see paragraph (f) of this seciton.
§ 173.301(k)	If the cylinder has features providing valve protection, it is unnecessary for the outside packaging to provide this protection.	In § 173.301, paragraph (k) would be revised to read as follows: § 173.301 *General requirements for shipment of compressed gases in cylinders.* * * * * * (k) *Outside packagings.* * * * (1) Outside packagings must provide protection for the cylinder. Unless the cylinder has a protective collar or neckring, the outside packaging must provide protection to the valve against accidental functioning and damage. * * * * *
§ 173.302(a)(5)(iv)	Present wording limits the service pressure on the cylinder to 3,000 psig, whereas the reason for the present wording is to prevent the charging pressure for oxygen from exceeding 3,000 psig. There is no reason why a higher design pressure cylinder should be excluded as long as the oxygen pressure limit is not exceeded.	In § 173.302, paragraph (a)(5) (iv) would be revised to read as follows: (iv) The pressure in the cylinder may not exceed 3,000 psig at 70 °F.
§ 173.304(a)(2)	To reinstate the 4BW225 to the list of cylinders authorized for the transportation of sulfur dioxide. This cylinder was inadvertently omitted in Docket HM-176 (46 FR 62452, December 24, 1981).	In § 173.314(a)(2) the Table would be amended by adding "DOT-4B225" in the third column for the entry "Sulfur dioxide".
§ 173.314(c) Note 6 of Table.	The present wording of Note 6 states in part that the discharge capacity of each of these safety relief devices must be sufficient to prevent building up of pressure in the tank in excess of ¾ of the test pressure of the tank. In § 179.102-1, paragraph (a)(3) uses a 82.5 percent figure. The AAR has requeisted that this discrepancy be corrected.	In § 173.314, the third sentence of Note 6 following the Table would be revised to read as follows: Note 6: * * * The discharge capacity of each of these safety relief devices must be sufficient to prevent building up of pressure in the tank in excess of 82½ precent of the tank test pressure. * * *
§ 173.315(c)	Docket HM-115 (48 FR 27674, June 16, 1983) revised paragraph (c)(1); however, that portion which read "The vapor pressure (psig) at 115 °F. must not exceed the design pressure of the cargo tank or portable tank container" was inadvertently omitted.	In § 173.315, paragraph (c) would be revised to read as follows: (c) Except as otherwise provided, the loading of a liquefied gas into a cargo tank or portable tank shall be determined by weight or by a suitable liquid level gauging device. The vapor pressure (psig) at 115 °F. must not exceed the design pressure of the cargo tank or portable tank container. The liquid portion of the gas shall not fill the tank at 105 °F. if the tank is insulated, or at 115 °F. if the tank is uninsulated, except that this requirement shall not apply to: * * * * *
§ 173.316	To provide filling limits for "air, refrigerated liquid" in cylinders	In § 173.316, paragraph (c)(2) would be amended by inserting the word "air" immediate before the work "argon", and the table would be amended by adding a column for "air" immediately preceding the column for "argon" to read as follows: (2) * * *

Pressure control valve setting (maximum start-to-discharge pressure, psig)	Maximum permitted filling density (percent by weight) Air
45	82.5
75	80.3
105	78.4
170	76.2
230	75.1
295	73.3
360	70.7
450	65.9
540	62.9
625	60.1
Design Service Temperature (°F.)	−320

Regulation affected	Reason(s) for proposed change	Proposed amendment
§ 173.318(b)(2)	To require the use of a primary and a secondary system of pressure relief devices on a cargo tank used in atmospheric gas (except oxygen) and helium, cryogenic liquid service. Proposed change is in response to a petition from the Compressed Gas Association.	In § 173.318, paragraphs (b)(2)(i)(B), (b)(2) (iii) and (iv) would be revised to read as follows: (B) *Tanks in atmoshperic gas (except oxygen) and helium, cryogenic liquid service.* (i) The primary system of pressure relief valve or valves must have a flow capacity equal to or greater than that specified in 4.1.10.1.1 of CGA Pamphlet S1.2. The inlet connection shall not be less than ½" nominal pipe size. The combined pressure relief system must have a flow capacity equal to or greater than that calculated by the applicable formula in paragraph 5.3.2 or paragraph 5.3.3 of CGA Pamphlet S-1.2. * * * * * (iii) The secondary system of frangible discs of additional pressure relief valves must have the minimum capacity specified in paragraph (b)(2)(i) of this section, at a pressure not exceeding 150 percent of the tank design pressure (iv) The primary system of pressure relief valves must have a liquid flow capacity (rated at a pressure not exceeding 120 percent of the tank design pressure), that equals of exceeds the maximum rate at which the tank is to be filled. However, a rating pressure, for purposes of flow capacity not exceeding 150 percent of the tank design pressure is authorized on a tank used in atmospheric gas (except oxygen) and helium, cryogenic liquid service.
§ 173.318(f)(2) & (3).	To provide filling limits for "air, refrigerated liquid" and to increase the filling limit authorized for "hydrogen" when shipped in cargo tanks. Proposed changes respond to petitions from Air Products and Union Carbide Corp.	In § 173.318, paragraph (f)(2) would be amended by removing the word "argon" and inserting in its place the words "Air, argon", and the Table would be amended by adding a column for "air" immediately preceding the column for "argon," and paragraph (f)(3) would be amended by adding an entry in the Table for "hydrogen".

* * * * *

(f) * * *

(2) * * *

PRESSURE CONTROL VALVE SETTING OR RELIEF VALVE SETTING

Maximum set-to-discharge pressure (psig)	Maximum permitted filing density (percent by weight) air
30	80.3
40	79.2
50	78.0
55	77.3
60	76.9
80	75.3
85	75.1
100	73.0
105	73.7
120	72.2
140	71.4
145	70.9

PRESSURE CONTROL VALVE SETTING OR RELIEF VALVE SETTING—Continued

Maximum set-to-discharge pressure (psig)	Maximum permitted filing density (percent by weight) air
180	68.3
200	67.3
250	63.3
275	62.3

PRESSURE CONTROL VALVE SETTING OR RELIEF VALVE SETTING—Continued

Maximum set-to-discharge pressure (psig)	Maximum permitted filing density (percent by weight) air
325	59.4
Design Service Temperature	Minus 320 °F.

(3) * * *

PRESSURE CONTROL VALVE SETTING OR RELIEF VALVE SETTING

Maximum set-to-discharge pressure (psig)	Maximum permitted filing density (percent by weight)			
	Carbon Monoxide	Ethylene	Hydrogen	Methane or natural gas
* * * * *				
150			4.5	

Regulation affected	Reason(s) for proposed change	Proposed amendment
§ 173.320	At present, shipments of atmospheric gas and helium, cryogenic liquid, in packagings authorized under this section do not have to conform with Subparts A and B of Part 173, and ## 174.1 and 177.804. It was never the intent to except these cryogenic liquids from the above referenced sections. A change is needed to prevent the shipment of leaking packagings	In §§ 173.320 the last sentence in paragraph (a) would be revised to include a reference to paragraph (a)(3); paragraph (a)(3) would be redesignated as (a)(4), and a new paragraph (a)(3) would be added to read as follows: (3) Subparts A and B of Part 173, and §§ 174.1 and 177.804 of this subchapter.
§ 173.965	On November 17, 1983, Docket No. HM-166-0 (48 FR 52306) inadvertently removed § 173.965. However, cotton is listed in the § 172.101 Table and reference § 172.965	§ 173.965 would be added to read as follows: § 173.965 *Cotton and other fibers.* Cotton and fibers jute, hemp, flax, sisal, coir, kapok, or similar vegetable fibers, when offered for transportation by water, must be packaged in bales, securely and tightly bound with rope, wire, or other similar means.
§ 174.9(b)	Reference paragraph states that heater coil inlet and outlet pipes must be left open for drainage. The Pennzoil Products Company reports that steam is applied only during the coldest portion of the winter season. When steam is applied, the heater caps must be left off to allow proper drainage. However, 95% of the time steam is not applied and removing and reapplying heater caps at the loading site, except during the cold season is time consuming and serves no useful purpose. The RSPA proposes to change the present word "must" to read "may"	In § 174.9 paragraph (b) would be revised to read as follows: (b) An empty tank car which previously contained a hazardous material and which is tendered for movement or received in interchange must have all manhole covers, outlet valve reducers, outlet valve caps, outlet valve cap plugs, end plugs, and plugs or caps or other openings securely in their proper places, except that heater coil inlet and outlet pipes may be left open for drainage.
§ 176.76(g)(2)	Construction standards for small passenger vessels certificated by the U.S. Coast Guard under 46 CFR Subchapter T are much less stringent then the standards for large passenger vessels. The Coast Guard believes that these small vessels are not suitable for the carriage of hazardous materials in portable tanks when carrying a full complement of passengers. These small vessels (commonly referred to as T-Boats) are used on a regular basis to carry passengers and supplies to offshore platforms and drill rigs. The Coast Guard has controlled this potential problem in the past by placing an endorsement on the vessel's Certificate of Inspection which permits them to carry hazardous materials in portable tanks only when no passengers are on board.	In § 176.76, paragraph (g)(2) would be revised to read as follows: (2) Small passenger vessels of 100 gross tons, or less, may carry a hazardous material in a portable tank only when 16 or less passengers are on board and only when specifically authorized by the Officer-In-Charge, Marine Inspection, by endorsement on the vessel's Certificate of Inspection.
§177.834(k)	The American Trucking Association, Inc., (ATA) has petitioned for the removal of paragraph (k) which reads as follows: "(k) *Access to mixed ladings.* Flammable solids, oxidizing materials, or corrosive liquids, when transported on a motor vehicle with other lading not otherwise forbidden, shall be so loaded as to provide ready access thereto for shifting or removal." The ATA believes that carrier operating practices should dictate how the weight of the load should be distributed throughout the trailer to insure an optimum level of vehicle stability and compliance with weight laws. The motor carrier also should be given the flexibility to load the trailer to minimize the possibility of lighter packages being crushed by heavier freight	In § 177.834, paragraph (k) would be removed and reserved. Also reference to paragraph (k) in the beginning of Sections §§ 177.835, 177.837, 177.838, 177.839, 177.840, and 177.841 would be amended to read (j).
§ 177.841(e)	To prohibit a motor carrier from carrying poisons or an irritating material in the passenger compartment of a motor vehicle. Incidents have occurred where a driver has placed a hazardous material (poison) in the passenger compartment and the packaging leaked which endangered the driver	In § 177.841, paragraph (e) would be revised by adding a sentence at the end to read as follows: (e) * * * No motor carrier may transport a packaging containing a material labeled "Poison", or "Poison gas", or "Irritant" in the drivers compartment of a motor vehicle.
§ 177.848(b)	This paragraph reads "cyanides or cyanide, mixtures must not be loaded or stored with acids or corrosive liquids." Cyanides and cyanide mixtures do not present an undue hazard by being stored next to or even by being mixed with corrosive liquids that are alkaline Several commenters have requested that this unnecessary restriction be removed	In § 177.848, paragraph (b) would be revised to read as follows: (b) Cyanides or cyanide mixtures must not be loaded or stored with acids or any other acidic materials which could release hydrocyanic acid from cyanides.
§ 178.42-14	For most specifications cylinders, any identification in the sidewall is prohibited. This proposed change clarifies that the markings on a DOT 3E cylinder may be stamped in the sidewall	In § 178.42-14, paragraph (a) would be revised to read: (a) Marking on each cylinder by stamping plainly and permanently on shoulder, top head, neck, or sidewall as follows: * * * * *
§ 178.46-4(a) §178.46-5(d)(1) and (2). § 178.46-6(c) § 178.46-8(e)	To correct and update the DOT-3AL Specification and to prohibit use of aluminum alloys with harmful quantities of lead and bismuth. The proposed threading requirements are expected to be included in all high pressure cylinder specifications in a future rulemaking. The proposal to authorize the 4D size tensil specimen for a second test to qualify a cylinder lot was indicated as acceptable in the preamble to Docket No. HM-176 but was not included in the final rule. Authorization to use the 4D bar in a second test does not apply to cylinders with sidwall thickness of 9/16 inch and less. RSPA believes that a valid test using the 4D size speciment cannot be obtained in this thickness range	In § 178.46-4, paragraph (a) would be revised to read as follows: § 178.46-4 *Duties of the Inspector.* (a) The inspector shall determine that all materials are in compliance with the requirements of this specification. * * * * * In § 178.46-5, Table 1 and footnote 2 of Table 2 in paragraph (d) would be revised to read as follows: § 178.46-5 *Authorized material and identification of material.* * * * * * (d) * * *

(1) CHEMICAL COMPOSITION LIMITS [1]

[Chemical Composition (in weight percent)]

Aluminum Assoc. alloy designation No.	Si	Fe	Cu	Mn	Mg	Cr	Zn	Ti	Pb	Bi	Other [2]		Al
											Each	Total	
6351	0.7–1.3	0.50	0.10	0.40–0.80	0.40–0.80	.....	0.20	0.20	0.01	0.01	0.05	0.15	Remainder.
6061	0.40–0.80	0.70	0.15–0.40	0.15	0.80–1.20	0.04–0.35	0.25	0.15	0.01	0.01	0.05	0.15	Remainder.

[1] ASIM B 221–76 Standard Specification for Aluminum-Alloy Extruded Bars, Rods Shapes, and Tubes, Table 1 Chemical Composition Limits, except for Pb and Bi. Limits are in percent maximum unless otherwise indicated.

[2] Analysis is regularly made only for the elements for which specific limits are shown, except for unalloyed aluminum. If, however, the presence of other elements is suspected to be, or in the course of routine analysis is indicated to be in excess of specified limits, further analysis is made to determine that these other elements are not in excess of the amount specified. (Aluminum Association Standards and Data-Sixth Edition 1979).

Regulation affected	Reason(s) for proposed change	Proposed amendment
		(2) *Mechanical Property Limits.* * * * * * 1"D" represents specimen diameters. When the cylinder wall is greater than 5/16 inch thick, a retest without reheat treatment using the 4D size specimen is authorized if the test using the 2 inch size specimen fails to meet elongation requirements. * * * * * In § 178.46–6, paragraph (c) would be revised to read as follows: § 178.46–6 *Manufacture.* * * * * * (c) Thickness of the cylinder base may not be less than the prescribed minimum wall thickness of the cylindrical shell. The cylinder base must have a basic torispherical, hemispherical, or ellipsoidal interior base configuration where the dish radius is no greater than 1.2 times the inside diameter of the shell. The knuckle radius may not be less than 12 percent of the inside diameter of the shell. The interior base contour may deviate from the true torispherical, hemispherical or ellipsoidal configuration provided, (1) any areas of deviation are accompanied by an increase in base thickness; (2) all radii of merging surfaces are equal to or greater than the knuckle radius; (3) each design has been qualified by successfully passing the cycling tests in § 178.46–6(f); and (4) that detailed specifications of the base design are available to the inspector. * * * * * In § 178.46–8, paragraph (e) would be revised to read as follows: § 178.46–8 *Openings.* * * * * * (e) All openings must be threaded. Threads must comply with the following: (1) Each thread must be clean cut, even, without checks, and to gauge. (2) Taper threads, when used, must compy with one of the following: (i) American Standard Pipe Thread (NPT) type must comply with the requirements of Federal Standard H–28 (1978), Section 7. (ii) National Gas Taper Thread (NGT) type must compy with the requirements of Federal Standard H–28 (1978), Sections 7 and 9. (iii) Other taper threads in compliance with other standards may be used provided the length is not less than that specified for NPT threads. (3) Straight threads when used must comply with one of the following: (i) National Gas Straight Thread (NGS) type must comply with the requirements of Federal Standard H–28, (1978), Sections 7 and 9. (ii) Unified Thread (UN) type must comply with the requirements of Federal Standard H–28 (1978), Section 2. (iii) Controlled Radius Root Thread (UNJ) type must comply with the requirements of Federal Standard H–28 (1978), Section 4. (iv) Other straight threads in compliance with other recognized standards may be used provided that the requirements in (4) below are met. (4) All straight threads must have at least 6 engaged threads, a tight fit, and a factor of safety in shear of at least 10 at the test pressure of the cylinder. Shear stress must be calculated by using the appropriate thread shear area in accordance with Federal Standard H–28 (1978), Appendix A5, Section 3.
§ 178.51–10(d) § 178.61–10(b)	At the present time, these two sections state that for cylinders with wall thicknesses less than 0.100 inch, the ratio of tangential length to outside diameter shall not exceed 4.0. The 4.0 does not apply consistently. It is not in Specification 4B and is not in any of the seamless cylinder specifications. Based on a request from a cylinder manufacturer the RSPA is proposing to change the "4.0" to "4.1".	In § 178.51–10, paragraph (d) would be revised to read as follows: § 178.51–10 *Wall thickness.* * * * * * * (d) For cylinders with a wall thickness less than 0.100 inch, the ratio of tangential length to outside diameter may not exceed 4.1. In § 176.61–10, paragraph (b) would be revised as follows: In § 178.61–10 *Wall thickness.* * * * * * (b) For cylinders with a wall thickness less than 0.100 inch, the ratio of tangential length to outside diameter may not exceed 4.1.
§ 178.53–9(a)	Editorial correction. The wall thickness for DOT Specification 4D cylinders states that the minimum wall for any container having a capacity of 1,100 cubic inches or less is 0.40 inch. The RSPA proposes to correct the "0.40" to read "0.04".	In § 178.53–9, paragraph (a) would be amended by changing 0.40 to read 0.04.
§ 178.54	To our knowledge, DOT Specification 4B240–FLW; welded or welded and brazed cylinders with fusion-welded longitudinal seam are not being made. At the time this specification was added to Part 178, Specification 4BW was not available. Therefore, since the 4B240-FLW cylinder is no longer being made and the 4BW cylinder is available, we are proposing to remove DOT Specification 4B240–FLW from Part 178. Part 173 would not be affected.	In Part 178, § 178.54 would be removed in its entirety.

Regulation affected	Reason(s) for proposed change	Proposed amendment
§ 178.245–1(a)	To remove the requirement that DOT Specification 51 portable tanks be postweld heat treated. Manufacturers of DOT–51 portable tanks, made for certain austenitic stainless steels, maintain that postweld heat treatment does not enhance the integrity of the tank. The ASME Code does not require postweld heat treatment on this particular type of steel because such treatment is not beneficial. RSPA agrees with the manufacturer's position.	In § 178.245–1, the introductory text of paragraph (a) would be revised to read as follows: § 178.245–1 *Requirements for design and construction.* (a) Tanks must be seamless or welded steel construction or combination of both and must have a water capacity in excess of 1,000 pounds. Fusion welded tanks must be postweld heat treated and radiographed to provide the highest joint efficiency provided by the ASME Code, except that postweld heat treatment of tanks made from austenitic stainless steel grades 304L, 316L, 321 and 347 shall be as required by the ASME Code. Tanks must be designed and constructed in accordance with and fullfill the requirements of the ASME Code. Tanks constructed in accordance with the requirements of Part UHT of the ASME Code must comply with the following additional requirements: • • • • •
§ 179.100–13(a)	The referenced paragraph discusses the bolting of venting, loading and unloading valves to seatings on manway covers. The AAR has requested that the word "directly" be removed because the present wording can be interpreted as prohibiting the use of intervening eductor pipe flange between a valve and a manway cover.	In § 179.100–13, the second sentence in paragraph (a) would be revised to read as follows: § 179.100–13 *Venting, loading and unloading valves, measuring and sampling devices.* (a) * * * The valves shall be bolted to seatings on the manway cover, except as provided in § 179.103. * * *
§ 179.100–14(a)(1). § 179.100–14(a)(3).	To improve railroad safety by (1) increasing the minimum allowable vertical clearance requirements for bottom outlets; (2) regulating the use of supplementary bottom outlet fittings; and (3) clarifying the requirement for bottom outlet and short breakage groove requirements.	In § 179.100–14, paragraph (a)(1) and (a)(3) would be revised to read as follows: (a) * * * (1) The extreme projection of the bottom washout equipment may be no more than that allowed by Appendix E of the AAR Specifications for Tank Cars. (2) * * * (3) If the bottom washout nozzle extends 6 inches or more from shell of tank, a V-shaped breakage groove must be cut (not cast) in the upper part of the outlet nozzle at a point immediately below the lowest part of the inside closure seat or plug. In no case shall the nozzle wall thickness at the root of the "V" be more than ¼-inch. Where the nozzle is not a single piece, provision must be made for the equivalent of the breakage groove. The nozzle must be of a thickness to insure that accidental breakage will occur at or below the "V" groove or its equivalent. On cars without continuous center sills, the breakage groove or its equivalent must not be more than 15 inches below the tank shell. On cars with continuous center sills, the breakage groove or its equivalent must be above the bottom of the center sill construction.
§ 179.102–2(a)(3)	The Chlorine Institute has requested that this subparagraph be updated to allow the use of a new insulation package on future tank cars for chlorine. A fire test was conducted and the fire protection capability of the ceramic fiberglass fiber system is excellent and well below the targeted limit of 483 degrees. F. Without sacrificing any other properties.	In § 179.102–2, paragraph (a)(3) would be revised to read as follows: § 179.102–2 *Chlorine.* (a) * * * (3) Insulation must be 4 inches minimum thickness of corkboard or of self-extinguishing polyurethane foam or must be 2 inches minimum thickness of 4 pounds per cubic foot minimum density ceramic fiber covered by 2 inches minimum thickness of glass fiber. • • • • •
§ 179.102–13	To improve railroad safety by requiring that hydrogen fluoride tank cars be constructed of corrosion resistant materials.	§ 179.102–13 would be revised to read as follows: § 179.102–13 *Hydrofluoric acid, anhydrous.* (a) Tank cars used to transport hydrofluoric acid, anhydrous, must comply with the following special requirements: (1) Bottom openings in tank are prohibited. (2) Plates for the tank shell, heads and manway must comply with Specification ASTM A516, Grade 70 normalized, or ASTM A537, Class 1. (3) Tanks must be postweld heat treated at 1,100 °F minimum; postweld heat treatment at the alternate lower temperatures listed in AAR Specifications for Tank Cars, Appendix W, is prohibited. (4) If welding or welded repairs are required on the tank shell, heads or manway nozzle after the tank is postweld heat treated, the tank or area repaired must be postweld heat treated again after the welding is completed. In such instances, the temperature must be controlled to provide protection for the adjacent metal to prevent a harmful temperature gradient. (5) The maximum hardness of the weld in the heat-affected zone may be no more than Brinell 237 (Rockwell C 22), measured on the production test plate on the cross section, after welding and final post-weld heat treatment. (6) Valves, valve parts, and other appurtenances normally in contact with the lading must comply with the National Association of Corrosion Engineers' Publication MR–01–75 and must be approved for hydrogen fluoride service. Ferritic stainless steels may not be used. (7) Safety relief valves must be in combination with either a breaking pin device or a frangible disc. See § 179.100–15(b) and (c). (8) Fasteners used in valve assemblies must conform to the National Association of Corrosion Engineers' Publication MR–01–75 and must be approved for hydrofluoric acid, anhydrous. Ferritic stainless steels may not be used. Studs, bolts, and nuts used to fasten any valves or fittings to the cover plate or the cover plate to the manway ring must meet the following specifications: (a) Studs and bolts: ASTM A–193–B7M; or ASTM A–193–B7-maximum hardness may be no more than Brinell 237 (Rockwell C–22); or ASTM A–320–L7-maximum hardness may be no more than Brinell 237 (Rockwell C–22). (2) Nuts ASTM A–194–2M; or ASTM A–194–2–maximum hardness may be no more than Brinell 237 (Rockwell C–22). (9) Each tank must be marked "HYDROGEN FLOURIDE" in accordance with § 172.330.

Regulation affected	Reason(s) for proposed change	Proposed amendment
§ 179.103-5(b)(1).. § 179.103-5(b)(4)..	To improve railroad safety.....	In § 179.103-5, paragraphs (b)(1) and (b)(4) would be revised to read as follows: (b) * * * (1) The extreme projection of the bottom outlet equipment may be no more than that allowed by Appendix E of the AAR Specifications for Tank Cars. All bottom outlet reducers and closures and their attachments must be secured to car by at least 3/8-inch chain, or its equivalent, except that bottom outlet closure plugs may be attached by ¼-inch chain. When the bottom outlet closure is of the combination cap and valve type, the pipe connection to the valve must be closed by a plug, cap, or approved quick coupling device. the bottom outlet equipment should include only the valve, reducers and closures that are necessary for the attachment of unloading fixtures. The permanent attachment of supplementary exterior fittings must be approved by the Director, Office fo Hazardous Materials Transportation. * * * * * * (4) If the outlet nozzle extends 6 inches or more from shell of tank, a V-shaped breakage groove must be cut (not cast) in the upper part fo the outlet nozzle at a point immediately below the lowest part of valve closest to the tank. In no case shall the nozzle wall thickness at the root of the "V" be more than ¼ inch. On cars without continuous center sills, the breakage groove or its equivalent must not be more than 15 inches below the tank shell. On cars with continuous center sills, the breakage groove or its equivalent must be above the bottom of the center sill construction. * * * * * *
§ 179.200-7 Tables.	The Association of American Railroads has requested that referenced section be amended to resolve the confusion that exists between the AAR Specification for Tank cars, Appendix M and the ASTM Specifications covering the variation of minimum elongation between the welded condition and the as rolled base metal.	In § 179.200-7, the third column of the Tables in paragraphs (b), (c), (d), (e), and (f) would be revised to read as follows: Minimum elongation in 2 inches (percent) weld metal (longitudinal)
§ 179.200-13.....	The specifications for pressure tank car tanks recognize that many nozzle-to-tank joints are neither the butt nor lap-joint types (§ 179.100-12(a)). The specifications for non-pressure tank car tanks require that such joints be of the butt or lap-joint type (§ 179.200-13 (c). The AAR has requested that the two sets of specifications be consistent.	In § 179.200, § 179.200-13 would be revised to read as follows: § 179.200-13 *Manway ring or flange, safety relief device flange, bottom outlet nozzle flange, bottom washout nozzle flange and other attachments and openings.* (a) These attachments shall be fusion welded to the tank and reinforced in an approved manner in compliance with the requirements of Appendix E, Figure 10, of the AAR Specifications for Tank cars. (b) The opening in the manway ring shall be at least 16 inches in diameter except that acid resistant lined manways shall be at least 18 inches in diameter before lining. (c) The manway ring of flange, if riveted to the dome or tank, shall be of cast, forged or fabricated steel, malleable iron or other malleable metals. (d) The manway ring or flange, if welded to the dome, tank or nozzle, shall be made of cast, forged or fabricated metal. The metal of the dome, tank, or nozzle shall be compatible with the manway ring or flange, so that they may be wilded together. (e) The openings for the manway or other fittings shall be reinforced in an approved manner.
§ 179.200-17 (a)(1), (a)(6), (a)(7), (b)(1), and (b)(3).	The AAR contends that the present wording is unclear and recommends these proposed changes.	In § 179.200-17, paragraphs (a)(1), (a)(6), (a)(7), (b)(1), and (b)(3) would be revised to read as follows: (a) * * * (1) The extreme projection of the bottom outlet equipment may be no more than that allowed by Appendix E of the AAR Specifications for Tank Cars. All bottom outlet reducers and closures and their attachments must be secured to the car by at least ⅜-inch chain, or its equivalent, except that the bottom outlet closure plugs may be attached by ¼-inch chain. When the bottom outlet closure is of the combination cap and valve type, the pipe connection to the valve must be closed by a plug, cap, or approved quick coupling device. The bottom outlet equipment should include only the valve, reducers and closures that are necessary for the attachment of unloading fixtures. The permanent attachment of supplementary exterior fittings must be approved by the Director, Office of Hazardous Materials Transportation. * * * * * * (6) To provide for the attachment of unloading connections, the discharge end of the bottom outlet nozzle or reducer, the valve body of the exterior valve, or some fixed attachment thereto, must be provided with one of the following arrangements or an approved modification thereof. (See Appendix E, Fig. E17 of the AAR Specifications for Tank Cars for illustrations of some of the possible arrangements.) (i) A bolted flange closure arrangement including a minimum 1-inch NPT pipe plug (see Fig. E17.1) or including an auxiliary valve with a threaded closure. (ii) A threaded cap closure arrangement including a minimum 1-inch NPT pipe plug (see Fig. E17.2) or including an auxiliary valve with a threaded closure. (iii) A quick-coupling device using a threaded plug closure of at least 1-inch NPT or having a threaded cap closure with a minimum 1-inch NPT pipe plug (see Fig. E17.3 through E17.5). A minimum 1-inch auxiliary test valve with a threaded closure may be substituted for the 1-inch pipe plug (see Fig. E17.6). If the threaded cap closure does not have a pipe plug, or integral auxiliary test valve, a minimum 1-inch NPT pipe plug must be installed in the outlet nozzle above the closure (see Fig. E17.7).

Regulation affected	Reason(s) for proposed change	Proposed amendment
		(iv) A two-piece quick-coupling device using a clamped dust cap which must include an in-line auxiliary valve, either integral with the quick-coupling device or located between the primary bottom outlet valve and the quick-coupling device. The quick-coupling device closure dust cap or outlet nozzle must be fitted with a minimum 1-inch NPT closure (see Fig. E17.8 and E17.9). (7) If the outlet nozzle extends 6 inches or more from the shell of the tank, a V-shaped breakage groove must be cut (not cast) in the upper part of the outlet nozzle at a point immediately below the lowest part of valve closest to the tank. In no case shall the nozzle wall thickness at the root of the "V" be more than ¼ inch. The outlet nozzle on interior valves or the valve body on exterior valves may be steam jacketed, in which case the breakage groove or its equivalent must be below the steam chamber but above the bottom of center sill construction. If the outlet nozzle is not a single piece, or if exterior valves are applied, provisions must be made for the equivalent of the breakage groove. On cars without continuous center sills, the breakage groove or its equivalent must be no more than 15 inches below the tank shell. On cars with continuous center sills, the breakage groove or its equivalent must be above the bottom of the center sill construction. • • • • •
		(b) • • • 1. The extreme projection of the bottom washout equipment may be no more than that allowed by Appendix E of the AAR Specifications for Tank Cars. • • • • •
		(3) If the washout nozzle extends 6 inches or more from the shell of the tank, a V-shaped breakage groove must be cut (not cast) in the upper part of the nozzle at a point immediately below the lowest part of the inside closure seat or plug. In no case shall the nozzle wall thickness at the root of the "V" be more than ¼ inch. Where the nozzle is not a single piece, provisions must be made for the equivalent of the breakage groove. The nozzle must be of a thickness to insure that accidental breakage will occur at or below the "V" groove or its equivalent. On cars without continuous center sills, the breakage groove or its equivalent must not be more than 15 inches below the outer shell. On cars with continuous centersills, the breakage groove or its equivalent must be above the bottom of the center sill construction.
§ 179.202-8	See § 173.245(a) Note 2	In § 179.202, § 179.202-8, § 179.202-11, and § 179.202-16 would be revised to read as follows: § 179.202-8 *Chloracetyl chloride.* Tank cars used to transport chloracetyl chloride must have a nickel cladding with a minimum thickness of 1/16. Nickel cladding in tanks must have a minimum nickel content of at least 99 percent. Specification DOT-103ANW tank car tanks used to transport chloracetyl chloride must be fabricated of nickel containing not more than 1 percent iron. Metal test coupons for welding procedure qualification must contain not more than 1 percent iron. All cast metal parts of the tank in contact with the lading must have a minimum nickel content of 96.7 percent. • • • • •
§ 179.202-11	Present wording requires phosphorus trichloride to be transported in certain lined tank cars. § 173.271(a)(11) does not require a lining for DOT 103A, 103AW, and 111A100F2 tank cars.	In § 179.202-11 the second and third sentences would be revised to read as follows: § 179.202-11 *Phosphorus oxybromide, phosphorus oxychloride, phosphorus trichloride, and thio-phosphoryl chloride.* • • • Specification 103ANW tank cars used to transport transport phosphorus oxybromide, phosphorus oxychloride, phosphorus trichloride, and thiophosphoryl chloride, tanks must be fabricated of solid nickel containing not more than 1 percent iron. Metal test coupon for welding procedure qualification must contain not more than 1 percent iron. All cast metal parts of the tank in contact with the lading must have a minimum nickel content of approximately 96.7 percent. Specification 103A tank cars used to transport phosphorus trichloride must be lead-lined steel, or made of steel with a nicked cladding of a least 10 percent of the shell thickness. Specifications 103AW, 111A100F2, or 111A60W2 tank cars used to transport phosphorus trichloride must be lead-lined steel or made of steel with a minimum thickness of nickel cladding of 1/16-inch. Nickel cladding must have a minimum nickel content of at least 99 percent. Specification 103EW tank cars used to transport phosphorus trichloride and thiophosphoryl chloride must have tanks fabricated from Type 316 stainless steel. Unlined Specification 103A, 103AW, 111A100F2, or 111A100W2 tank cars are authorized for phosphorus trichloride only.
§ 179.202-16	See § 173.245(a) Note 2	§ 179.202-16 *Chloroacetic acid, liquid.* (a) Tank cars used to transport Chloro-acetic acid, liquid, must have tanks with nickel cladding of at least 20 percent of the shell thickness. Nickel cladding in tanks must have a minimum nickel content of a least 99 percent. • • • • •
		(b) Chloracetic acid, anhydrous, when shipped as a liquid must be shipped in Specification 103ANW tank car tanks fabricated of nickel containing not more than 1 percent iron, or in Specification 103AW or 111A60W2 tank car tanks with nickel cladding of at least 20 percent of the shell thickness, or be provided with a suitable corrosion resistant coating or lining. Metal test coupons for welding procedure qualification must contain not more than 1 percent iron. Nickel cladding in tanks must have a minimum nickel content of at least 99 percent.
		In § 179.202-18, paragraphs (a)(1), (a)(6), (b)(1), and (b)(3) would be revised to read as follows:
xd		(a) • • • (1) The extreme projection of the bottom outlet equipment may be no more than that allowed by Appendix E of the AAR Specifications for Tank Cars. All bottom outlet reducers and closures and their attachments must be secured to care by at at least ⅜-inch chain, or its equivalent, except that bottom outlet closure plugs may be attached by ¼-inch chain. When the bottom outlet closure is of the combination cap and valve type, the pipe connection to the valve must be closed by a plug, or cap. The bottom outlet equipment should include only the valve, reducers and closures that are necessary for the attachment of unloading fixtures. The permanent attachment of supplementary exterior fittings must be approved by the Director, Office of Hazardous Materials Transportation. • • • • •

Regulation affected	Reason(s) for proposed change	Proposed amendment
		(6) If outlet nozzle and its closure extends below the bottom of the outer shell, a V-shaped breakage groove must be cut (not cast) in the upper part of the outlet nozzle at a point immediately below the lowest part of the valve closest to the tank. In no case shall the nozzle wall thickness at the root of the "V" be more than ¼ inch. The outlet nozzle or the valve body may be steam jacketed, in which case the breakage groove or its equivalent must be below the steam chamber but above the bottom of the center sill construction. If the outlet nozzle is not a single piece or if exterior valves are applied, provision must be made for the equivalent of the breakage groove. On cars without continuous center sills, the breakage groove or its equivalent must not be more than 15 inches below the outer shell. • • • • • (b)* * * 1. The extreme projection of the bottom washout equipment may be no more than that allowed by Appendix E of the AAR Specifications for Tank Cars. • • • • • (3) If washout nozzle extends below the bottom of the outer shell, a V-shaped breakage groove must be cut (not cast) in the upper part of the nozzle at a point immediately below the lowest part of the inside closure seat or plug. In no case shall the nozzle wall thickness at the root of the "V" be more than ¼ inch. Where the nozzle is not a single piece, provisions must be made for the equivalent of the breakage groove. The nozzle must be of a thickness to insure that accidential breakage will occur at or below the "V" groove or its equivalent. On cars without continuous center sills, the breakage groove or its equivalent must not be more than 15 inches below the outer shell. On cars with continuous center sills, the breakage groove or its equivalent must be above the bottom of the center sill construction.
§ 179.220-19(c).....	To make an exception for the use of safety vents on DOT 115A tank cars for the transportation of chloroprene. See § 179.222 for more information.	In § 178.220-19, paragraph (c) would be amended by changing the last sentence to read as follows: (c) * * * Except for tanks for chloroprene (see § 179.222-1), tanks equipped with vents must be stenciled "Not for flammable liquids".
§ 179.221-1.....	To add a "Special reference" to the Table in § 179.221-1 for the 115A60W1 and 115A60W6 tank cars to coincide with the proposed change to § 179.222 for the transportation of chloroprene.	In § 179.221, the Table would be amended by adding an entry to read as follows: • • • • •
Special reference..	§ 179.222-1	179.222-1
§ 197.222.....	To authorize DOT 115A tank cars for the transportation of chloroprene to be equipped with safety vents instead of safety relief valves. Chloroprene is classed as a flammable liquid. Also, it is polymerizable and its vapor discharging through a relief valve orifice may condense, build up, and plug the orifice. A minimum safety vent diameter of 12 inches is being proposed.	In Part 179, a new section § 179.222 would be added to read as follows: § 179.222 *Special commodity requirements for DOT 115A tank car tanks.* In addition to § 179.220 and § 179.221 the following requirements are applicable: § 179.222-1 *Chloroprene.* DOT 115A tank car tanks used to transport chloroprene must be equipped with a safety vent with a diameter not less than 12 inches complying with § 179.221-1 instead of a safety relief valve. The outer shell shall be stenciled "CHLOROPRENE ONLY" on both sides in letters not less than 1½ inches high.
§ 179.222-1.....		
§ 179.301.....	To add a new DOT Specification 110A600-W to the list of authorized multi-unit tank car tanks.	In § 179.301, the Table would be amended by adding the following: § 179.301 *Individual specification requirements for multi-unit tank car tanks.* (a) * * *

DOT specifications	100A600-W
Bursting pressure, psi (see 179.300-5)	1500
Minimum thickness shell, inches	⅝
Test pressure psi (see § 179.300-16)	600
Safety relief devices psi (see § 179.300-15)	
Start-to-discharge, or burst maximum psi	450
Vapor-tight, minimum psi	360

[1] None specified.

Issued in Washington, DC on May 23, 1986 under authority delegated in 49 CFR Part 106, Appendix A.

Alan I. Roberts,

Director, Office of Hazardous Materials Transportation.

[FR Doc. 86-12136 Filed 6-2-86; 8:45 am]

BILLING CODE 4910-60-M

Research and Special Programs Administration

49 CFR Part 192

[Docket No. PS-90, Notice 1]

Transportation of Natural and Other Gas by Pipeline; Period for Confirmation or Revision of Maximum Allowable Operating Pressure

AGENCY: Research and Special Programs Administration (RSPA).

ACTION: Notice of Proposed Rulemaking (NPRM).

SUMMARY: This notice proposes to clarify the rule that a pipeline's maximum allowable operating pressure (MAOP) must be confirmed or revised within 18 months after an increase in class location. Some operators have misinterpreted this rule to bar later pressure testing to qualify a current MAOP if that pressure is reduced during the 18-month period. The proposed rule would clarify that the previously established MAOP of pipelines that have had their MAOP reduced to meet the 18-month deadline may be reinstated by pressure testing at any time after the 18-month period.

DATE: Interested persons are invited to submit written comments on this proposal by July 18, 1986. Late filed comments will be considered to the extent practicable.

ADDRESS: Comments should be sent to the Dockets Branch, Room 8426, Research and Special Programs Administration, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590, and identify the docket and notice numbers. All

comments and other docket material are available in Room 8426 for inspection and copying between the hours of 8:30 am and 5:00 pm each working day.

FOR FURTHER INFORMATION CONTACT: L.M. Furrow, (202) 426–2392.

Address: Copies of the proposal and documents related thereto may be obtained from the Dockets Branch, Room 8426, Research and Special Programs Administration, U.S. Department of Transportation, 400 Seventh Street, SW., Washington, DC 20590, (202) 426–3148.

SUPPLEMENTARY INFORMATION: By letter of January 22, 1985, (P–30), The Gas Piping Technology Committee of the American Society of Mechanical Engineers (ASME) petitioned RSPA to clarify the period allowed for confirmation or revision of a pipeline's MAOP following a change in class location.

Whenever an increase in population density causes an increase in a pipeline's designated class location, and the hoop stress corresponding to the pipeline's MAOP is not commensurate with the new class location, the MAOP must be confirmed or revised according to the rules in § 192.611. Paragraph (e) of § 192.611 requires that the confirmation or revision be completed within 18 months of the change in class location.

Section 192.611 permits alternative actions for pipelines that have not previously been pressure tested for at least 8 hours to at least 90 percent of specified minimum yield strength. These alternatives are (1) reduce the pipeline's MAOP (to the level where the corresponding hoop stress does not exceed the stress permitted for new pipelines in that class location (section 192.611(b)), or (2) pressure test the pipeline and either reestablish the original MAOP or establish a lower MAOP based on that test (section 192.611(c)).

Because of operating constraints, reductions in market demand or gas supplies, or other economic factors, operators sometimes find it more practical to reduce a pipeline's MAOP rather than conduct a pressure test, even though the existing MAOP may be needed to handle anticipated future operating conditions. However, ASME argues that the 18-month rule of § 192.611(e) thwarts this option because it makes the two alternatives mutually exclusive. In other words, ASME says operators who choose pressure reduction as a temporary measure are precluded from pressure testing at a later date to confirm the existing MAOP. As a result, operators are compelled to test within 18 months to preserve an existing MAOP, even though that pressure level is not necessary for current operations.

In contrast, RSPA does not believe that the 18-month rule blocks operators who choose one compliance option from later selecting the other. In an August 29, 1984, response to a waiver request from Tennessee Gas Pipeline (Petition 84–5W), RSPA said:

> [T]here is nothing in § 192.611(b), (c), or (e) that bars application of paragraph (c) once paragraph (b) has been applied. Under § 192.611, paragraphs (b) and (c) provide independent alternative ways to comply with the confirmation or revision rule. Choosing pressure reduction under paragraph (b) initially is not inconsistent in any way with testing later under paragraph (c) to confirm the preexisting MAOP. Paragraph (e) requires that confirmation or revision be done within 18 months after a class change occurs. It does not preclude taking alternative compliance action at a later date.

Still, RSPA is concerned, because of the ASME petition and the earlier waiver request, that § 192.611(e) may, in practice, be adversely affecting economical pipeline operations of some operators. Therefore, RSPA is proposing to amend § 192.611 by revising paragraph (e)(2) as set forth below to make it clear that operators who reduce a pipeline's MAOP under § 192.611(b) within the 18-month period may at a later date reinstate the preexisting MAOP by pressure testing under § 192.611(c).

Classification

Since this proposed rule will have a positive effect on the economy of less than $100 million a year, it will result in cost savings to consumers, industry, and government agencies, and no adverse impacts are anticipated the proposed rule is not "major" under Executive Order 12291. Also, it is not "significant" under Department of Transportation procedures (44 FR 11034). RSPA believes that the proposed rule will reduce the costs of confirmation or revision programs by reducing the number of pressure tests unnecessarily done to satisfy the current rule. However, this savings is not expected to be large enough to warrant preparation of a Draft Regulatory Evaluation.

Based on the facts available concerning the impact of this rulemaking action, I certify pursuant to Section 605 of the Regulatory Flexibility Act that the action will not, if adopted as final, have a significant economic impact on a substantial number of small entities.

List of Subjects in 49 CFR Part 192

Pipeline safety, Maximum allowable operating pressure.

PART 192—[AMENDED]

In view of the above, RSPA, proposes to amend Part 192 to Title 49 of the Code of Federal Regulations as follows:

1. The authority citation for Part 192 continues to read as set forth below:

Authority: 49 U.S.C. 1672; U.S.C. 1804; 49 CFR 1.53 and Appendix A of Part 1.

2. Section 192.611(e)(2) would be revised to read as follows:

§ 192.611 Change in class location: Confirmation or revision of maximum allowable operating pressure.

* * * * *

(e) * * *

(2) Confirmation or revisicn due to changes in class location that occur on or after July 1, 1973, must be completed within 18 months of the change in class location. Pressure reduction under paragraph (b) of the section within the 18-month period does not preclude establishing a maximum allowable operating pressure under paragraph (c) at a later date.

Issued in Washington, DC on May 29, 1986, under authority delegated by 49 CFR Part 106, Appendix A.

Robert L. Paullin,

Director, Office of Pipeline Safety.

[FR Doc. 86–12353 Filed 6–2–86; 8:45 am]

BILLING CODE 4910–60–M

Notices

Federal Register
Vol. 51, No. 106
Tuesday, June 3, 1986

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Citizen's Advisory Committee on Equal Opportunity; Meeting

In accordance with Section 10(a) (2) of the Federal Advisory Committee Act (Pub. L. 92–463), an announcment is made of the following committee meeting:

Name: Citizen's Advisory Committee on Equal Opportunity.

Date: July 28–30, 1986.

Place: Park East Hotel, 916 East State Street, Milwaukee, Wisconsin 53202.

Time: 9:00 a.m.—5:00 p.m.

Purpose:

—Advise the Secretary on the effectiveness of compliance program directives;

—Review all aspects of the Department's policies, practices, and procedures on Equal Opportunity;

—Recommend changes in Department rules, regulations, and orders to assure USDA activities are free from discrimination;

—Additionally, the Committee will focus on:

—Review of the status of Equal Employment Opportunity in the Department of Agriculture;

—Employment programs and constituent services in the Forest Service;

The meeting is open to the public. Persons may participate in the meeting as time and space permit. Persons who wish to address the Committee at the meeting or who wish to file written comments before or after the meeting should contact: Lawrence Bembry, Associate Director, Equal Opportunity, Office of Advocacy and Enterprise, 201 14th Street, SW., Room 2305 Auditors Building, Washington, DC 20024 (202) 447–5681.

Written statements may be submitted until July 11, 1986.

Lawrence Bembry,

Associate Director, Equal Opportunity, Office of Advocacy and Enterprise.

[FR Doc. 86–12423 Filed 6–2–86; 8:45 am]

BILLING CODE 3410–04–M

Food and Nutrition Service

Level of Donated-Food Assistant or Cash in Lieu Thereof for Nutrition Program for the Elderly Fiscal Year 1985

AGENCY: Food and Nutrition Service, USDA.

ACTION: Notice.

SUMMARY: This notice announces the level of assistance for the Nutrition Program for the Elderly for Fiscal Year 1985. Based on final meal participation data reported for Fiscal Year 1985, 225,293,379 meals were served. Given the total funding of $120,800,000 for Fiscal Year 1985, the per-meal level of assistance is set at $.53618 per meal in accordance with section 311(c)(2) of the Older Americans Act of 1965 (the Act).

EFFECTIVE DATE: October 1, 1984.

FOR FURTHER INFORMATION CONTACT: Beverly King, Chief, Program Administration Branch, Food Distribution Division, Food and Nutrition Service, U.S. Department of Agriculture, Alexandria, Virginia 22302 (703) 756–3660.

SUPPLEMENTARY INFORMATION: This action, which implements a mandatory provision of section 311 of the Act, has been reviewed under Executive Order 12291 and Secretary's Memorandum No. 1512–1 and has been classified as "nonmajor" because it does not meet any of the three criteria in the definition of "major rule" in the Executive Order. It will not have an annual effect on the economy of $100 million or more, will not cause a major increase in costs or prices, and will not have a significant impact on competition, employment, productivity, innovation, or the ability of U.S. enterprises to compete. The purpose of this action is to notify States of the level of donated-food assistance to be povided for nutrition services under the Act during Fiscal Year 1985.

This notice imposes no new reporting or recordkeeping provisions that are subject to Office of Management and Budget review.

The Nutrition Program for the Elderly was funded at $120,800,000 for Fiscal Year 1985 to carryout the provisions of section 311(a)(4). On August 19, 1985, (50 FR 33363) a **Federal Register** Notice was published stating that the total number of meals served in Fiscal Year 1985 might exceed the previous estimate of 212,800,000. It was estimated that the total number of meals might range between 220 million and slightly above 230 million, based on estimates of meals to be served and that the per-meal reimbursement rate would depend on the final meal count. Final meal participation data has now been reported to the Department which indicates that 225,293,379 meals were served. Therefore, the per-meal reimbursement rate is set at $.53618 for Fiscal Year 1985. The final meal rate is calculated by dividing the $120,800,000 funding level by 225,293,379 meals served. This rate applies to all eligible meals served in fiscal year 1985.

(42 U.S.C. 3030a)

(Catalog of Federal Domestic Assistance No. 10.550)

Dated: May 22, 1986.

Robert E. Leard,

Administrator.

[FR Doc. 86–12354 Filed 6–2–86; 8:45 am]

BILLING CODE 3410–30–M

Food Stamp Program: Adjustment of Income Eligibility Standards

AGENCY: Food and Nutrition Service, USDA.

ACTION: General notice.

SUMMARY: The Department is adjusting the limits on gross and net income which certain households may have and still be eligible for food stamps. The Food Stamp Act of 1977, as amended, requires the Department to make this adjustment each year. By adjusting the income elibility limits, the Program takes into account changes in the cost of living,

EFFECTIVE DATE: July 1, 1986.

FOR FURTHER INFORMATION CONTACT: Thomas O'Connor, Supervisor, State Management Section, Administration and Design Branch, Program Development Division, Family Nutrition Programs, Food and Nutrition Service, USDA, Alexandria, Virginia, 22302, (703) 756–3385.

SUPPLEMENTARY INFORMATION:

Classification

Executive Order 12291

The Department has reviewed this action under Executive Order 12291 and Secretary's Memorandum No. 1512-1. This action will affect the economy by less than $100 million a year. It will not significantly raise costs or prices for consumers, industries, government agencies or geographic regions. There will not be significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. Therefore, the Department has classified this action as "not major".

Executive Order 12372

The Food Stamp Program is listed in the Catalog of Federal Domestic Assistance under No. 10.551. For the reasons set forth in the Final Rule related Notice to 7 CFR Part 3015, Subpart V (48 FR 29115), this program is excluded from the scope of Executive Order 12372, which requires intergovernmental consultation with State and local officials.

Publication

State agencies must implement the new standards on July 1, 1986, and these offices need adequate advance notice of the new standards to carry out all steps necessary for them to meet the implementation deadline. Based on regulations published at 47 FR 46485-46487 (October 19, 1982), annual statutory adjustments to the gross and net monthly income eligibility standards are issued by General Notices published in the **Federal Register** and not through rulemaking procedures.

Regulatory Flexibility Act

The Administrator of the Food and Nutrition Service has certified that this action will not have a significant economic impact on a substantial number of small entities. The action will primarily affect State and local welfare agencies and future food stamp applicants. The effect upon the welfare agencies is not significant.

Paperwork Reduction Act

This action does not contain reporting or recordkeeping requirements subject to approval by the Office of Management and Budget (OMB).

Background

All households, except those in which all members are receiving public assistance or supplemental security income benefits, must meet the Food Stamp Program's income eligibility standards. Households which contain an elderly or disabled member must meet the net income eligibility standards—equal to the poverty level. Households which do not contain an elderly or disabled member must meet both the net income eligibility standards and the gross income eligiblity standards—equal to 130 percent of the poverty level. In addition, elderly individuals (and their spouses) unable to prepare meals because of certain disabilities may be considered separate households even if they are living and eating with another household. The Act limits this exception to those persons who meet both of the following requirements: (1) Their own income may not exceed the net income eligibility standards, and (2) the income of those with whom they reside may not exceed 165 percent of the poverty level. The Food Stamp Act requires that the gross and net income eligibility standards take into account the annual adjustments of the poverty guidelines issued by the Department of Health and Human Services. The elderly/disabled standards must also be adjusted. These adjustments are set forth in the following tables.

NEW MONTHLY INCOME ELIGIBILITY STANDARDS

[100% of poverty level]

Household size	48 States [1]	Alaska	Hawaii
1	447	559	515
2	604	755	695
3	760	950	875
4	917	1,146	1,055
5	1,074	1,342	1,235
6	1,230	1,538	1,415
7	1,387	1,734	1,595
8	1,544	1,930	1,775
Each additional member	+157	+196	+180

[1] Includes District of Columbia, Guam and Virgin Islands.

GROSS MONTHLY INCOME ELIGIBILITY STANDARDS

[130% of poverty level]

Household size	48 States [1]	Alaska	Hawaii
1	581	726	669
2	785	981	903
3	988	1,235	1,137
4	1,192	1,490	1,371
5	1,396	1,745	1,605
6	1,599	1,999	1,839
7	1,803	2,254	2,073
8	2,007	2,508	2,307
Each additional member	+204	+255	+234

[1] Includes District of Columbia, Guam and Virgin Islands.

GROSS MONTHLY INCOME ELIGIBILITY STANDARDS FOR HOUSEHOLDS WHERE ELDERLY/DISABLED A SEPARATE HOUSEHOLD

[165% of poverty level]

Household size	48 States [1]	Alaska	Hawaii
1	737	922	849
2	996	1,245	1,146
3	1,254	1,568	1,443
4	1,513	1,891	1,740
5	1,771	2,214	2,037
6	2,030	2,537	2,334
7	2,288	2,860	2,631
8	2,547	3,184	2,928
Each additional member	+259	+324	+297

[1] Includes District of Columbia, Guam and Virgin Islands.

(91 Stat. 958 (7 U.S.C. 2011-2029)

Dated: May 27, 1986.

Robert E. Leard,

Administrator.

[FR Doc. 86-12425 Filed 6-2-86; 8:45 am]

BILLING CODE 3410-30-M

DEPARTMENT OF COMMERCE

Minority Business Development Agency

Applications Under Minority Business Development Center Program

May 23, 1986.

AGENCY: Minority Business Development Agency.

ACTION: Notice.

SUMMARY: The Minority Business Development Agency (MBDA) announces that it is soliciting applications under its Minority Business Development Center (MBDC) Program to operate a MBDC for a 3 year period, subject to available funds. The cost performance for the first 12 months is estimated at $694,118 for the project performance period of September 1, 1986 to August 31, 1987. The first year cost for the MBDC will consist of $590,000 in Federal funds and a minimum of $104,118 in non-Federal funds (which can be a combination of cash, in-kind contribution and fees for services).

The I.D. Number for this project will be 09-10-86015-01.

The funding instrument for the MBDC will be a cooperative agreement and competition is open to individuals, non-profit organizations, local and state governments, American Indian tribes and educational institutions.

The MBDC will provide management and technical assistance to eligible clients for the establishment and operation of businesses. The MBDC program is designed to assist those minority businesses that have the highest potential for success. In order to accomplish this, MBDC support MBDC

programs that can: coordinate and broker public and private sector resources on behalf of minority individuals and firms; offer them a full range of management and technical assistance; and serve as a conduit of information and assistance regarding minority business.

Applications will be judged on the experience and capability of the firm and its staff in addressing the needs of minority business individuals and organizations; the resources available to the firm in providing management and technical assistance; the firm's proposed approach to performing the work requirements included in the application; and the firm's estimated cost for providing such assistance. It is advisable that applicants have an existing office in the geographic region for which applying.

The MBDC will operate for a three (3) year period with periodic reviews culminating in annual evaluations to determine if funding for the project should continue. Continued funding will be at the discretion of MBDC based on such factors as the MBDC's satisfactory performance, the availability of funds, and Agency priorities.

A pre-application conference to assist all interested applicants will be held at the following address and time:

Minority Business Development Agency, U.S. Department of Commerce, 221 Main Street, Room 1280, San Francisco, California 94105

June 11, 1986 at 10:00 A.M.

Proposals Are To Be Mailed to the Following Address

Minority Business Development Agency, U.S. Department of Commerce, San Francisco Regional Office, 221 Main Street, Room 1280, San Francisco, California 94105, 415/974-9597.

DATES: Closing date: The closing date for application is June 26, 1986. Applications must be postmarked by midnight, June 26, 1986.

FOR FURTHER INFORMATION CONTACT: Dr. Xavier Mena, Regional Director, San Francisco Regional Office.

SUPPLEMENTARY INFORMATION: Questions concerning the preceding information, copies of application kits and applicable regulations can be obtained at the above address.

May 22, 1986.

11.800 Minority Business Development. (Catalog of Federal Domestic Assistance)

Victor Casaus,

Regional Director, San Francisco Regional Office.

[FR Doc. 86-12191 Filed 6-2-86; 8:45 am]

BILLING CODE 3510-21-M

National Oceanic and Atmospheric Administration

Marine Mammals Permit Application; NMFS, Northwest and Alaska Fisheries Center (P77#19)

Notice is hereby given that an Applicant has applied in due form for a Permit to take marine mammals as authorized by the Fur Seal Act of 1966 (16 U.S.C. 1151-1187), and the Marine Mammal Protection Act of 1972 (16 U.S.C. 1361-1407), and the Regulations Governing the Taking and Importing of Marine Mammals (50 CFR Part 216).

1. Applicant:

a. Name—Northwest and Alaska Fisheries Center, National Marine Fisheries Service.

b. Address—7600 Sand Point Way, N.E., Seattle, Washington 98115.

2. Type of Permit: Scientific research

3. Species: Northern fur seal *(Callorhinus ursinus).*

4. Number and Type of Take:

To take annually for five (5) years up to 1,500 females, 2,500 males and 32,500 pups of either sex may be captured by the use of physical and/or chemical restraint for marking (which may include the use of tags, paint, bleach, shearing, branding, tattooing, and injection of tetracycline); handling (which may include weighing, examining, measuring, obtaining blood, milk, and swab samples, identifying sex, and administering lavage and enema procedures); and release near the capture site. All of the above takes may occur an unspecified number of times per individual each year.

Of the above: Up to 250 may have instruments affixed which may include sensors, recorders, radio transmitters, and satellite-linked electronics. Take by instrumenting will involve a maximum of 10 recaptures per individual each year for instrument monitoring; up to 40 will be injected with labeled water which may include holding individuals captive, injecting radioisotopic water, and obtaining blood and milk samples. This type of take will involve a maximum of 5 recaptures and processing per individual per year; up to 50 will be taken by experimental entangling which may include placing net webbing and/or other debris onto the necks of individuals. A maximum of 10 recaptures per individual per year will be taken for the evaluation of the effects of the debris; and up to 50 will be held captive, which may consist of restraining individuals near their site of capture for periods of up to one month. Take by holding captive may occur up to a maximum of 5 times per individual each year.

In addition, throughout the duration of the permit 300 animals will be taken by incidental entanglement and/or death associated with research on interactions between large fragments of marine debris and 1,800 will be taken by intentional sacrifice or incidental killing. An unspecified number may be taken by incidental harassment by ground surveys, aerial surveys, boat or ship surveys, and activities supporting northern fur seal research. An unspecified amount of specimen material will be collected from animals killed during harvest activities and found dead during the course of the research. The applicant is also requesting authorization to import specimen material collected by official representatives of the governments of Canada, Japan, or the USSR for scientific research.

5. Location of Activity: Alaska: Pribilof Islands, Bering Sea, Boqoslof Island, Aleutian Islands; and the Channel Islands of California.

6. Period of Activity: 5 years.

Concurrent with the publication of this notice in the **Federal Register**, the Secretary of Commerce is forwarding copies of this application to the Marine Mammal Commission and the Committee of Scientific Advisors.

Written data or views, or requests for a public hearing on this application should be submitted to the Assistant Administrator for Fisheries, National Marine Fisheries Service, U.S. Department of Commerce, Washington, DC 20235, within 30 days of the publications of this notice. Those individuals requesting a hearing should set forth the specific reasons why a hearing on this particular application would be appropriate. The holding of such hearing is at the discretion of the Assistant Administrator for Fisheries.

Documents submitted in connection with the above application are available for review in the following offices:

Assistant Administrator for Fisheries, National Marine Fisheries Service, 3300 Whitehaven Street, NW., Washington, DC;

Director, Northwest Region, National Marine Fisheries Service, 7600 Sand Point Way, N.E., BIN C15700, Seattle, Washington 98115;

Director, Alaska Region, National Marine Fisheries Service, 709 West 9th Street, Federal Building, Juneau, Alaska 99802; and

Director, Southwest Region, National Marine Fisheries Service, 300 South Ferry Street, Terminal Island, California 90731.

Dated: May 29, 1986

Henry R. Beasley,

Director, Office of International Fisheries, National Marine Fisheries Service.

[FR Doc. 86-12372 Filed 6-2-86; 8:45 am]

BILLING CODE 3510-22-M

National Technical Information Service

Intent to Grant Exclusive Patent License; United Merchants and Manufacturers, Inc.

The National Technical Information Service (NTIS), U.S. Department of Commerce, intends to grant to United Merchants and Manufacturers, Inc. having a place of business in New York, NY an exclusive right in the United States to manufacture, use, and sell products embodied in the invention entitled "Process for Reinforced Yarn with Glass Fiber Core," U.S. Patent 4,541,231. The patent rights in this invention have been assigned to the United States of America, as represented by the Secretary of Commerce.

The proposed exclusive license will be royalty-bearing and will comply with the terms and conditions of 35 U.S.C. 209 and 37 CFR 404.7. The proposed license may be granted unless, within sixty days from the date of this published Notice, NTIS receives written evidence and argument which establishes that the grant of the proposed license would not serve the public interest.

Inquiries, comments and other materials relating to the proposed license must be submitted to Douglas J. Campion, Office of Federal Patent Licensing, NTIS, Box 1423, Springfield, VA 22151.

Douglas J. Campion,

Office of Federal Patent Licensing, U.S. Department of Commerce, National Technical Information Service.

[FR Doc. 86-12384 Filed 6-2-86; 8:45 am]

BILLING CODE 3510-04-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Issuance of Marine Mammals; Permit; Dr. Lanny H. Cornell and Mr. Edward D. Asper (P373)

On January 27, 1986, notice was published in the **Federal Register** (51 FR 3382) that an application had been filed by Dr. Lanny H. Cornell, 1720 South Shores Road, San Diego, California 92109 and Mr. Edward D. Asper, 7007 Sea World Drive, Orlando, Florida 32821 to import unspecified number of all species of marine mammals for scientific research.

Notice is hereby given that on May 22, 1986 as authorized by the provisions of the Marine Mammal Protection Act of 1972 (16 U.S.C. 1361-1407) and the Endangered Species Act of 1973 (16 U.S.C. 1531-1543), the National Marine Fisheries Service and the Fish and Wildlife Service jointly issued a Permit for the above taking subject to certain conditions set forth therein.

Issuance of this Permit, as required by the Endangered Species Act of 1973, is based on a finding that such Permit; (1) was applied for in good faith; (2) will not operate to the disadvantage of the endangered species which are the subject of this Permit; (3) and will be consistent with the purposes and policies set forth in Section 2 of the Endangered Species Act of 1973. This Permit was also issued in accordance with, and is subject to Parts 220-222 of Title 50 CFR, the National Marine Fisheries Service regulations governing endangered species permits and Part 17 of Title 50 CFR, the Fish and Wildlife Service regulations governing endangered species.

The Permit is available for review by interested persons in the following offices:

Assistant Administrator for Fisheries, National Marine Fisheries Service, 3300 Whitehaven Street, NW., Washington, DC;

Director, Southwest Region, National Marine Fisheries Service, 300 South Ferry Street, Terminal Island, California 90731;

Director, Northwest Region, National Marine Fisheries Service, 7600 Sand Point Way, NE., BIN C15700, Seattle, Washington 98115;

Director, Northeast Region, National Marine Fisheries Service, 14 Elm Street, Federal Building, Gloucester, Massachusetts 01930;

Director, Southeast Region, National Marine Fisheries Service, 9450 Koger Boulevard, St. Petersburg, Florida 33702; and

Director, Alaska Region, National Marine Fisheries Service, P.O. Box 1668, Juneau, Alaska 99802.

Dated: May 21, 1986.

Richard B. Roe,

Director, Office of Fisheries Management, National Marine Fisheries Service.

Dated: May 22, 1986.

R.K. Robinson,

Chief, Branch of Permits, Federal Wildlife Permit Office.

[FR Doc. 86-12373 Filed 6-2-86; 8:45 am]

BILLING CODE 3510-22-M

DEPARTMENT OF DEFENSE

Office of the Secretary

Defense Intelligence Agency Scientific Advisory Committee; Closed Meeting

AGENCY: Defense Intelligence Agency Scientific Advisory Committee, Defense.

ACTION: Notice of closed meeting.

SUMMARY: Pursuant to the provision of Subsection (d) of Section 10 of Pub. L. 92-463, as amended by Section 5 of Pub. L. 94-409, notice is hereby given that a closed meeting of a panel of the DIA Scientific Advisory Committee has been rescheduled from 17 June 1986 as follows:

DATE: 25 June 1986, 9:00 a.m. to 5:00 p.m.

ADDRESS: The DIAC, Bolling AFB, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Lieutenant Colonel Harold E. Linton, USAF, Executive Secretary, DIA Scientific Advisory Committee, Washington, DC 20301, (202/373-4930).

SUPPLEMENTARY INFORMATION: The entire meeting is devoted to the discussion of classified information as defined in Section 552b(c)(1), Title 5 of the U.S. Code and therefore will be closed to the public. Subject matter will be used in a special study on Microelectronics and Computers.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 86-12446 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-01-M

DOD Advisory Group on Electron Devices; Advisory Committee; Closed Meeting

SUMMARY: The DOD Advisory Group on Electron Devices (AGED) announces a closed session ad-hoc meeting.

DATE: The meeting will be held at 1700, Thursday 19 June 1986.

ADDRESS: Palisades Institute for

Research Services, Inc., 2011 Crystal Drive, Suite 307, Arlington, Va 22202.

FOR FURTHER INFORMATION CONTACT: Mr. Harry Summer, AGED Secretariat, 201 Varick street, New York, NY 10014.

SUPPLEMENTARY INFORMATION: The mission of the Advisory Group is to provide the Under Secretary of Defense of Research and Engineering, the Director, Defense Advanced Research Projects Agency and the Military Departments with technical advice on the conduct of economical and effective research and development programs in the area of electron devices.

The AGED Consultants Ad-Hoc meeting will be limited to the real-time review of the Science and Technology Review presented by the three Services to the Director, VHSIC/Electron Devices. The review will include details of classified defense programs thoughout.

In accordance with Section 10(d) of Pub. L. 92-463, as amended (5 U.S.C. App. II. 10(d) (1982)), it has been determined that this Advisory Group meeting concerns matters listed in 5 U.S.C. 552b(c)(1) (1982), and that accordingly, this meeting will be closed to the public.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

May 29, 1986.

[FR Doc. 86-12447 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-01-M

Department of the Navy

Naval Research Advisory Committee; Closed Meeting

Notice was published May 22, 1986, at 51 FR 11542, that the Naval Research Advisory Committee Panel on Automated Submarine Detection will meet on June 10-13, 1986. The meeting location on June 12 from 3:30 P.M. through 5:30 P.M. has been changed to ENSCO, Inc., 5400 Port Royal Road, Springfield, Virginia. The meeting location on June 13 from 1:00 P.M. through 3:30 P.M. has been changed to BB&N Laboratories, 1300 North 17th Street, Suite 400, Arlington, Virginia. All other information in the previous notice remains effective.

Dated: May 28, 1986.

William F. Roos, Jr.,

Lieutenant, JAGC, U.S. Naval Reserve, Federal Register Liaison Officer.

[FR Doc. 86-12391 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-AE-M

Naval Research Advisory Committee; Closed Meeting

Pursuant to the provisions of the Federal Advisory Committee Act (5 U.S.C. app.), notice is hereby given that the Naval Research Advisory Committee Panel on U.S. Navy Anti-Submarine Warfare Technology 1986-1996 will meet on June 18-20, 1986, at the Naval Research Laboratory, Building 43, Washington, DC. The meeting will commence at 8:30 A.M. and terminate at 5:30 P.M. on June 18; and commence at 8:30 A.M. and terminate at 5:00 P.M. on June 19 and 20, 1986. All sessions of the meeting will be closed to the public.

The purpose of the meeting is to evaluate the security of the present and future U.S. Navy surface fleet and undersea surveillance systems. The agenda will include technical briefings on the threat, surface ASW response, strategic and tactical performance requirements, undersea surveillance, and emerging technology. These briefings will contain information that is specifically authorized under criteria established by Executive order to be kept secret in the interest of national defense and is in fact properly classified pursuant to such Executive order. The classified and nonclassified matters to be discussed are so inextricably intertwined as to preclude opening any portion of the meeting. Accordingly, the Secretary of the Navy has determined in writing that the public interest requires that all sessions of the meeting be closed to the public because they will be concerned with matters listed in section 552b(c)(1) of title 5, United States Code.

For further information concerning this meeting contact: Commander T. C. Fritz, U.S. Navy, Office of Naval Research (Code 100N), 800 North Quincy Street, Arlington, VA 22217-5000, Telephone (202) 696-4870.

Dated: May 28, 1986.

William F. Roos, Jr.,

Lieutenant, JAGC, U.S. Naval Reserve, Federal Register Liaison Officer.

[FR Doc. 86-12393 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-AE-M

Naval Research Advisory Committee; Closed Meeting

Pursuant to the provisions of the Federal Advisory Committee Act (5 U.S.C. app.), notice is hereby given that the Naval Research Advisory Committee Panel on Under Ice Warfare Requirements will meet on June 24 and 25, 1986 at the Naval Research Laboratory, Washington, D.C. The meeting will commence at 8:00 A.M. and terminate at 5:00 P.M. on June 24 and 25, 1986. All sessions of the meeting will be closed to the public.

The purpose of the meeting is to understand, deal with, and exploit environmental surveillance issues in polar waters, identify what study has been done on the subject thus far, identify promising technologies, and drive operational requirements to deal with under ice anti-submarine warfare. The agenda will include technical briefings on the threat, maritime strategy and environmental considerations. These briefings will contain classified information that is specifically authorized under criteria established by Executive order to be kept secret in the interest of national defense and are in fact properly classified pursuant to such Executive order. The classified and nonclassified matters to be discussed are so inextricably intertwined as to preclude opening any portion of the meeting. Accordingly, the Secretary of the Navy has determined in writing that the public interest requires that all sessions of the meeting be closed to the public because they will be concerned with matters listed in section 552b(c)(1) of title 5, United States Code.

For further information concerning this matter contact: Commander T. C. Fritz, U.S. Navy, Office of the Chief of Naval Research (Code 00NR), 800 North Quincy Street, Arlington, VA 22217-5000, Telephone (202) 696-4870.

Dated: May 28, 1986.

William F. Roos, Jr.,

Lieutenant, JAGC, U.S. Naval Reserve, Federal Register Liaison Officer.

[FR Doc. 86-12394 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-AE-M

Privacy Act of 1974; New and Amended Systems of Records

AGENCY: Department of the Navy, DOD.

ACTION: Notice of a new and three amended systems of records.

SUMMARY: The Department of the Navy proposes to add a new and amend three existing systems of records in its inventory of systems of records subject to the Privacy Act of 1974.

DATES: This proposed action will be effective without further notice July 3, 1986, unless comments are received which would result in a contrary determination.

ADDRESS: Send any comments to Mrs. Gwen Aitken, Privacy Act Coordinator, Office of the Chief of Naval Operations (OP-09B30), Department of the Navy, The Pentagon, Washington, DC 20350-

2000, telephone: 202-697-1459, autovon: 227-1459.

SUPPLEMENTARY INFORMATION: The Department of the Navy systems of records notices subject to the Privacy Act of 1974 have been published in the **Federal Register** as follows:

FR Doc. 86-10763 (51 FR 18086) May 16, 1986

A new system report, as required by 5 U.S.C. 552a(o) of the Privacy Act was submitted on the new system on April 4, 1986, pursuant to paragraph 4b of Appendix I to OMB Circular No. A-130, "Federal Agency Responsibilities for Maintaining Records About Individuals," dated December 12, 1985. The proposed amendments are not within the purview of 5 U.S.C. 552a(o) of the Privacy Act which requires the submission of an altered systems report.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

May 29, 1986.

New System

N01571-1

SYSTEM NAME:

Reserve Financial Management/ Training System (RESFMS).

SYSTEM LOCATION:

Primary-Commander, Naval Reserve Force, 4400 Dauphine Street, New Orleans, LA 70146-500.

Decentralized segments—Naval Reserve Surface Force, Naval Reserve Air Force and their claimancies.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

All individuals who are members of the Naval Reserve and those that are recruited into the Naval Reserve Programs.

CATEGORIES OF RECORDS IN THE SYSTEM:

System comprises records reflecting information pertaining to reservist's Active Duty for Training (ACDUTRA) and associated personal information such as name/rank/grade, SSN, current address, academic, medical qualifications, schools and training information. The system also contains a Standard Document Number (SD) which is used to track cost of training, clothing and subsistence that is provided to the reservist.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

10 U.S.C. 5031.

PURPOSE(S):

To write, modify and cancel orders for Naval Reservists performing ACDUTRA; to issue seabags, death benefits paid, per diem, travel, subsistence, drill pay, ACDUTRA and Temporary Active Duty (TEMAC) pay, disability payments, bonuses, school costs and special pay such as flight and sea pay, and to monitor training needs.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

The Blanket Routing Uses that appear at the beginning of the Department of the Navy's compilation apply to this system.

POLICIES AND PRACTICES FOR STORING, RETRIEVING/ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Automated records are stored on magnetic tapes, disks and drums. Paper record, microfiche, printed reports and other related documents supporting the system are filed in cabinets and stored in authorized areas only.

RETRIEVABILITY:

Automated records are retrieved by SSN, name and standard document numbers.

SAFEGUARDS:

Within the computer center, controls have been established to distribute computer output over the counter only to authorized users. Specific procedures are also in force for the disposal of computer output. Output material in the sensitive category will be shredded. Computer files are kept in a secure, continuously manned area and are accessible only to authorized computer operators, programmers, enlisted management, placement, and distributing personnel who are directed to respond to valid, official requests for data. These accesses are controlled and monitored by the Security System.

RETENTION AND DISPOSAL:

History of ACDUTRA orders are maintained in the system for three years, then destroyed, Accounting documents are maintained in the system for three years (current year and two prior years). Paper documents for each year are destroyed one year after the lapse for the earliest appropriation year.

SYSTEM MANAGER(S) AND ADDRESS:

Commander, Naval Reserve Force, 4400 Dauphine Street, New Orleans, LA 70146-5000.

NOTIFICATION PROCEDURE:

Information should be obtained from the systems manager. Requesting individuals should specify their full names. Visitors should be able to identify themselves by a commonly recognized evidence of identity. Written requests must be signed by the requesting individual.

RECORD ACCESS PROCEDURE:

The agency's rules for access to records may be obtained from the system manager.

CONTESTING RECORD PROCEDURES:

The agency's rules for contesting contents and appealing initial determinations by the individual concerned may be obtained from the systems manager.

RECORD SOURCE CATEGORIES:

Individuals concerned, disbursing officers, Navy schools, and military command to which the individual is attached.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

AMENDMENTS

N01070-3

System name:

Navy Personnel Records System (51 FR 18094) May 16, 1986.

Changes:

Routine uses of records maintained in the system, including categories of users and the purposes of such uses:

After the third paragraph, insert a new entry: "To officials and employees of the Veterans Administration in the performance of their duties relating to approved research projects."

N03760-1

System name:

Individual Flight Activity Report (51 FR 18129) May 16, 1985.

Changes:

System name:

Delete the entire entry and substitute with the following: "Naval Flight Record Subsystem (NAVFLIRS)".

System location:

Delete the entire entry and substitute with the following: "The primary data base is maintained at the Navy Maintenance Support Office, Mechanicsburg, PA 17055. Secondary data bases are maintained at the Naval Safety Center, Naval Air Station, Norfolk, VA 23511 and at Commandant of the Marine Corps, Headquarters, U.S. Marine Corps, Washington, DC 20380. Local data bases are maintained at all Navy and Marine Corps aviation ships. (See Directory of the Department of the

Navy mailing addresses). Additional Marine Corps sites are FMFPAC ASC 06, Camp Smith, HA; RASC, Camp Pendleton, CA; RJE, Marine Corps Air Station, Cherry Point, NC; 6th FASC, Marine Corps Air Station, Iwakuni, Japan and ASC, Marine Corps Base, Quantico, VA."

Categories of individuals covered by the system:

Delete the entire entry and substitute with the following:

"All aeronautically designated commissioned Navy and Marine Corps officers and enlisted members assigned as aircrew members in the operation of an aircraft in accordance with the direction of competent authority."

Categories of records in the system:

In line two, delete the sentence beginning with: "Total flight * * *" and substitute with the following: "Records contain personal identification (name, rank, SSN), and specific technical data related to the flight of Naval aircraft."

Authority for maintenance of the System:

Delete the entry in its entirety and substitute with the following: "10 U.S.C. 5031."

Purpose(s):

Delete lines 1–19 and substitute with the following: "NAVFLIRS consolidates the collection of Naval flight data into a single, locally controlled collection and correction system, and implements a standard data collection source document (the Naval Flight Record OPNAV 3710/4) throughout the Navy and Marine Corps. It further establishes a single central data base containing all Naval flight data."

Policies and Practices for Storing, Retrieving, Accessing, Retaining, and Disposing of Records in the System:

Retrievability:

Delete the entry in its entirety and substitute with: "Individual records are primarily retrieved by a unique document number assigned to each naval flight record. Additionally, each of the data elements such as pilot's social security number, model aircraft and squardon may be used to retrieve individual records."

Safeguards:

Delete the entry in its entirety and substitute with: "Magnetic tapes are stored in limited access areas and handled by personnel that are properly trained in working with automated systems of records."

Retention and Disposal:

Delete the entry in its entirety and substitute with the following: "The primary data base and the secondary data base at the Naval Safety Center are permanent. Records in the secondary data base at Headquarters, U.S. Marine Corps are erased from tape when the individual is removed from active flight status. Local data bases purge all magnetic tape records after 6 months."

System Manager(s) and Address:

Delete the entry in its entirety and substitute with the following: "Commander, Naval Air Systems Command, Washington, DC 20361."

N06320–2

System name:

Family Advocacy Program System (51 FR 18191) May 16, 1986.

Changes:

Categories of individuals covered by the system:

In line 5, after the phrase: "* * * all persons * * *" delete the phrase: "* * * suspected of * * *" and replace with: "* * * reported for * * *".

Categories of records in the system:

At the end of the entry, add a new sentence as follows: "Sponsor's SSN is maintained for appropriate central registry accountability."

Amended Systems

N01070-3

SYSTEM NAME:

Navy Personnel Records System.

* * * * *

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

To officials and employees of other Departments and Agencies of the Executive Branch of government, upon request, in the performance of their official duties related to the management, supervision and administration of military personnel and the operation of personnel affairs and functions.

To officials and employees of the National Research Council in Cooperative Studies of the National History of Disease; of Prognosis and of Epidemology. Each study in which the records of members and former members of the naval service are used must be approved by the Commander, Naval Military Personnel Command.

To officials and employees of the Department of Health and Human Services, Veterans Administration, and Selective Service Administration in the performance of their official duties related to eligibility, notification and assistance in obtaining benefits by members and former members of the Navy.

To officials and employees of the Veterans Administration in the performance of their duties relating to approved research projects.

To officials and employees of Navy Relief and the American Red Cross in the performance of their duties related to assistance of the members and their dependents and relatives.

To duly appointed Family Ombudsmen in the performance of their duties related to the assistance of the members and their families.

To state and local agencies in performance of their official duties related to verification of status for determination of eligibility for Veterans Bonuses and other benefits and entitlements.

To officials and employees of the Office of the Sergent at Arms of the United States House of Representatives in the performance of their official duties related to the verification of the active duty naval service of members of Congress.

Information as to current military addresses and assignments may be provided to military banking facilities who provide banking services overseas and who are reimbursed by the Government for certain checking and loan losses. For personnel separated, discharged or retired from the Armed Forces information as to last known residential or home of record address may be provided to the military banking facility upon certification by a banking facility officer that the facility has a returned or dishonored check negotiated by the individual or the individual has defaulted on a loan and that if restitution is not made by the individual the United States Government will be liable for the losses the facility may incur.

To state, local, and foreign (within Status of Forces agreements) law enforcement agencies or their authorized representatives in connection with litigation, law enforcement, or other matters under the jurisdiction of such agencies.

When required by Federal statute, by Executive Order, or by treaty, personnel record information will be disclosed to the individual, organization, or governmental agency as necessary.

The Blanket Routine Uses that appear at the beginning of the Department of

the Navy's compilation also apply to this system.

* * * * *

NO3760-1

SYSTEM NAME:

Naval Flight Record Subsystem (NAVFLIRS).

SYSTEM LOCATION:

The primary data base is maintained at the Navy Maintenance Support Office, Mechanicsburg, PA 17055. Secondary data bases are maintained at the Naval Safety Center, Naval Air Station, Norfolk, VA 23511 and at Commandant of the Marine Corps, Headquarters, U.S. Marine Corps, Washington, DC 20380. Local data bases are maintained at all Navy and Marine Corps aviation ships. (See Directory of the Department of the Navy mailing addresses). Additional Marine Corps sites are FMFPAC ASC 06, Camp Smith, HA: RASC, Camp Pendleton, CA; RJE, Marine Corps Air Station, Cherry Point, NC; 6th FASC, Marine Corps Air Station, Iwakuni, Japan and ASC, Marine Corps Base, Quantico, VA.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

All aeronautically designated commissioned Navy and Marine Corps officers and enlisted members assigned as aircrew members in the operation of an aircraft in accordance with the direction of competent authority.

CATEGORIES OF RECORDS IN THE SYSTEM:

Records of each flight are submitted by the reporting custodian of the aircraft. Records contain personal identification (name, rank social security number), and specific technical data related to the flight of Naval aircraft.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

10 U.S.C. 5031

PURPOSE(S):

NAVFLIRS consolidates the collection of Naval flight data into a single, locally controlled collection and correction system, and implements a standard data collection source document (the Naval Flight Record OPNAV 3710/4) throughout the Navy and Marine Corps. It further establishes a single central data base containing all Naval flight data. Records are also provided to the Commander, Naval Military Personnel Command for promotional screening, detailing and compliance with minimum standards. Summaries of flight activity for Marine Corps personnel are provided to the Commandant of the Marine Corps. Records of specific pilots or categories of pilots are provided to contractors, if required, for projects either funded by or deemed potentially valuable to the Department of the Navy.

To the Naval Audit Service to investigate certain phrases of the Naval Aviation Program.

* * * * *

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

* * * * *

RETRIEVABILITY:

Individual records are primarily retrieved by a unique document number assigned to each naval flight record. Additionally, each of the data elements such as pilot's social security number, model aircraft and squadron may be used to retrieve individual records.

SAFEGUARDS:

Magnetic tapes are stored in limited access areas and handled by personnel that are properly trained in working with automated systems of records.

RETENTION AND DISPOSAL:

The primary data base and the secondary data base at the Naval Safety Center are permanent. Records in the secondary data base at Headquarters, U.S. Marine Corps are erased from tape when the individual is removed from active flight status. Local data bases purge all magnetic tape records after 6 months.

SYSTEM MANAGER(S) AND ADDRESS:

Commander, Naval Air Systems Command, Washington, DC 20361

* * * * *

NO6320-2

SYSTEM NAME:

Family Advocacy Program System.

* * * * *

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

All beneficiaries entitled to care at Navy medical and dental facilities who abuse or neglect is brought to the attention of appropriate authorities, and all persons reported for abusing or neglecting such beneficiaries.

CATEGORIES OF RECORDS IN THE SYSTEM:

Medical records of suspected and confirmed cases of family member abuse or neglect, also, investigative reports, correspondence, family advocacy committee reports, follow-up and evaluative reports, and any other supportive data assembled relevant to individual family advocacy program files. Sponsor's SSN is maintained for appropriate central registry accountability.

* * * * *

[FR Doc. 86-12448 Filed 6-2-86; 8:45 am]

BILLING CODE 3810-01-M

DEPARTMENT OF EDUCATION

Proposed Information Requests

AGENCY: Department of Education.

ACTION: Notice of Proposed Information Collection Requests.

SUMMARY: The Director, Information Resources Management Service invites comments on the proposed information collection requests as required by the Paperwork Reduction Act of 1980.

DATE: Interested persons are invited to submit comments on or before July 3, 1986.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Desk Officer, Department of Education, Office of Management and Budget, 726 Jackson Place, NW., Room 3208, New Executive Office Building, Washington, DC 20503. Requests for copies of the proposed information collection requests should be addressed to Margaret B. Webster, Department of Education, 400 Maryland Avenue, SW., Room 4074, Switzer Building, Washington, DC 20202.

FOR FURTHER INFORMATION CONTACT: Margaret B. Webster (202) 426-7304.

SUPPLEMENTARY INFORMATION: Section 3517 of the Paperwork Reduction Act of 1980 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with an agency's ability to perform its statutory obligations.

The Director, Information Resources Management Service publishes this notice containing proposed information collection requests prior to the submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g., new, revision, extension, existing or reinstatement; (2) Title; (3) Agency form number (if any); (4) Frequency of the

collection; (5) The affected public; (6) Reporting burden; and/or (7) Recordkeeping burden; and (8) Abstract. OMB invites public comment at the address specified above. Copies of the requests are available from Margaret Webster at the address specified above.

Dated: May 29, 1986.

George P. Sotos,

Director, Information Resources Management Service.

Office of Postsecondary Education

Type of Review: Extension.

Title: Application for Certification for Participation in Programs under Title IV of the Higher Education Act of 1965, as amended.

Agency Form Number: ED 633.

Frequency: Annually.

Affected Public: Businesses or other for profit.

Reporting Burden:

Responses: 1,500; Burden Hours: 3,000.

Recordkeeping Burden:

Recordkeepers: 0; Burden Hours: 0.

Abstract: This form is used by colleges, universities and vocational schools to apply to the Department of Education for certification to participate in student financial assistance programs under Title IV of the Higher Education Act of 1965, as amended.

Office of Postsecondary Education

Type of Review: Extension.

Title: Application for Grants and Contracts Under the Minority Institutions Science Improvement Program (MISIP).

Agency Form Number: ED 0007.

Frequency: Annually.

Affected Public: Businesses and other for profit; and non-profit institutions.

Reporting Burden:

Responses: 150; Burden Hours: 6,450.

Recordkeeping Burden:

Recordkeepers: 0; Burden Hours: 0.

Abstract: This form is used by applicants to provide the Department of Education with necessary information to competitively award grants and contracts under the Minority Institutions Science Improvement Program.

Office of Elementary and Secondary Education

Type of Review: Reinstatement.

Title: Application Form for Grants under Indian Education Programs.

Agency Form Number: ED 736 & 736-1.

Frequency: Annually.

Affected Public: State or local governments; non-profit institutions; small businesses or organizations.

Reporting Burden:

Responses: 1,500; Burden Hours: 45,000.

Recordkeeping Burden:

Recordkeeping: 0; Burden Hours: 0.

Abstract: This form is used to apply for grants under the programs authorized by the Indian Education Act, P.L. 92-318, as amended.

[FR Doc. 86-12452 Filed 6-2-86; 8:45 am]

BILLING CODE 4000-01-M

Educational Media Research, Production, Distribution, and Training

AGENCY: Department of Education.

ACTION: Application Notice Establishing Closing Date for Transmittal of New Applications for Fiscal Year 1986 Awards.

Applications are invited for new projects under the Educational Media Research, Production, Distribution and Training program.

Authority for this program is contained in Sections 651 and 652 of Part F of the Education of the Handicapped Act. (20 U.S.C. 1451, 1452)

Applications may be submitted by profit and nonprofit public and private agencies, organizations, and institutions.

The Educational Media Research, Production, Distribution, and Training program is designed to promote the educational advancement of handicapped persons by providing assistance for: (a) Conducting research on the use of educational media and technology for handicapped persons; (b) producing and distributing educational media for the use of handicapped persons, their parents, their actual or potential employers, and other persons directly involved in work for the advancement of handicapped persons; and (c) training persons in the use of educational media for the instruction of handicapped persons.

Closing Date for Transmittal of Applications

An application for a new project must be mailed or hand-delivered on or before July 18, 1986.

Applications Delivered by Mail

An application sent by mail must be addressed to the U.S. Department of Education, Application Control Center, Attention: CFDA Number 84.026, 400 Maryland Avenue, SW., Washington, DC 20202.

An applicant must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark.

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service.

(3) A dated shipping label, invoice, or receipt from a commercial carrier.

(4) Any other proof of mailing acceptable to the U.S. Secretary of Education.

If an application is sent through the U.S. Postal Service, the Secretary does not accept either of the following as proof of mailing: (1) A private metered postmark, or (2) a mail receipt that is not dated by the U.S. Postal Service.

An applicant should note that the U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, an applicant should check with its local post office.

An applicant is encouraged to use registered or at least first class mail.

Each late applicant will be notified that its application will not be considered.

Applications Delivered by Hand

An application that is hand-delivered must be taken to the U.S. Department of Education, Application Control Center, Room 3633, Regional Office Building 3, 7th and D Streets, SW., Washington, DC.

The Application Control Center will accept a hand-delivered application between 8:00 a.m. and 4:30 p.m. (Washington, D.C. time) daily, except Saturdays, Sundays, and Federal holidays.

An application for a new project that is hand-delivered will not be accepted by the Application Control Center after 4:30 p.m. on the closing date.

Intergovernmental Review

On June 24, 1983, the Secretary published in the **Federal Register** final regulations (34 CFR Part 79, published at 48 FR 29158 *et seq.*) implementing Executive Order 12372, entitled "Intergovernmental Review of Federal Programs." The regulations took effect September 30, 1983.

This program is subject to the requirements of the Executive Order and the regulations in 34 CFR Part 79. The objective of Executive Order 12372 is to foster an intergovernmental partnership and a strengthened federalism by relying on State and local processes for State and local government coordination and review of Federal financial assistance.

The Executive Order—

- Allows States, after consultation with local officials, to establish their own process for review and comment on proposed Federal financial assistance;
- Increases Federal responsiveness to State and local officials by requiring Federal agencies to accommodate State and local views or explain why those views will not be accommodated; and

• Revokes OMB Circular A-95.

Transactions with nongovernmental entities, including State postsecondary education institutions and federally recognized Indian tribal governments, are not covered by Executive Order 12372. Also excluded from coverage are research, development, or demonstration projects that do not have a unique geographic focus and are not directly relevant to the governmental responsibilities of a State or local government within that geographic area.

The following is a current list of States that have established a process, designated a single point of contact, and have selected this program for review:

Alabama	New Jersey
Arizona	New Mexico
Arkansas	New York
California	Northern Mariana Islands
Connecticut	North Dakota
Delaware	Ohio
Florida	Oklahoma
Guam	Oregon
Hawaii	Pennsylvania
Indiana	South Carolina
Kansas	South Dakota
Kentucky	Tennessee
Louisiana	Texas
Maine	Trust Territory
Massachusetts	Utah
Michigan	Vermont
Missouri	Virgin Islands
Montana	Virginia
Nebraska	Washington
Nevada	Wyoming
New Hampshire	

Immediately upon receipt of this notice, applicants which are governmental entities, including local educational agencies, must contact the appropriate State single point of contact to find out about, and to comply with, the State's process under the Executive Order. Applicants proposing to perform activities in more than one State should, immediately upon receipt of this notice, contact the single point of contact for each State and follow the procedures established in those States under the Executive Order. A list containing the single point of contact for each State is included in the application package for this program.

In States that have not established a process or chosen this program for review, State, areawide, regional, and local entities may submit comments directly to the Department.

All comments from State single points of contact and all comments from State, areawide, regional, and local entities must be mailed or hand-delivered by September 18, 1986 to the following address:

The Secretary, U.S. Department of Education, Room 4181 (84.026), 400 Maryland Avenue, SW., Washington, DC 20202. (Proof of mailing will be determined on the same basis as applications).

PLEASE NOTE THAT THE ABOVE ADDRESS IS NOT THE SAME ADDRESS AS THE ONE TO WHICH THE APPLICANT SUBMITS ITS APPLICATION. *DO NOT SEND APPLICATIONS TO THE ABOVE ADDRESS.*

Available Funds

It is estimated that approximately $1,000,000 will be available for support of one cooperative agreement manufacturer at least 33,000 additional Line 21 decoders during fiscal year 1986. These estimates of funding level do not bind the U.S. Department of Education to a specific number of awards or to the amount of any award unless that amount is otherwise specified by statute or regulations.

Priority for Funding

A notice of proposed annual funding priority for this program is published in this issue of the **Federal Register.**

Application Forms

Application forms and program information packages are expected to be available for mailing on June 6, 1986. These materials may be obtained by writing to the Captioning and Adaptation Branch, Special Education Programs, Department of Education, 400 Maryland Avenue, SW. (Switzer Building, Room 3511-M/S 2313), Washington, DC 20202.

Applications must be prepared and submitted in accordance with the regulations, instructions, and forms included in the program information packages. However, the program information is only intended to aid applicants in applying for assistance. Nothing in the program information package is intended to impose any paperwork, application content, reporting, or grantee performance requirements beyond those imposed under the statute and regulations.

The Secretary strongly urges that the narrative portion of the application not exceed 20 pages in length. The Secretary further urges that applicants not submit information that is not requested.

(Approved by the Office of Management and Budget under control number 1820-0028)

Applicable Regulations

Regulations applicable to this program include the following:

(a) The regulations governing the Educational Media Research, Production, Distribution and Training program (34 CFR Part 332). A Notice of Proposed Annual Funding Priority for this program is published in this issue of the **Federal Register.** Prospective applicants are advised that the proposed annual funding priority is subject to modification in response to public comments submitted within 30 days of publication. In the event any substantive changes are made in the priority or other requirements for a new project, applicants will be given the opportunity to amend or resubmit their applications.

(b) The Education Department General Administrative Regulations (EDGAR) (34 CFR Parts 74, 75, 77, 78, and 79).

For Further Information Contact

Dr. Malcolm J. Norwood, Chief, Captioning and Adaptation Branch, Special Education Programs, Department of Education, 330 C Street, SW. (Switzer Building, Room 3511-M/S 2313), Washington, DC 20202. Telephone: (202) 732-1177.

(20 U.S.C. 1451, 1452)

Dated: May 29, 1986.

Madeleine Will,

Assistant Secretary, Office of Special Education and Rehabilitative Services.

(Catalog of Federal Domestic Assistance No. 84.026, Educational Media Research, Production, Distribution, and Training)

[FR Doc. 86-12455 Filed 6-2-86; 8:45 am]

BILLING CODE 4000-01-M

Privacy Act of 1974; System of Records

AGENCY: Department of Education.

ACTION: Notice of a New System of Records.

SUMMARY: In accordance with the Privacy Act of 1974, as amended, the Secretary publishes this notice of a new system of records known as the Records of Educationally Disadvantaged Students Attending Private Schools Served Through Bypass Contracts. The new system will be used to provide contractors with information on test scores to identify private school students who are eligible for participation and to measure progress made by students in programs under Chaper 1 of the Education Consolidation and Improvement Act of 1981 (ECIA). The Secretary seeks comments on the proposed routine uses contained in this notice.

DATES: Comments on proposed routine uses must be submitted by July 3, 1986. The Department filed a report of the new system of records with the President of the Senate, the Speaker of the House of Representatives, and the Director, Office of Management and Budget (OMB)on May 29, 1986. This system of records will become effective

60 days after the report for the system of records was sent to these parties.

ADDRESSES: Comments on the proposed routine uses should be addressed to the Privacy Act Officer, Office of Planning, Budget, and Evaluation, Public Affairs Service, Department of Education, 400 Maryland Avenue, SW (Room 2089), Washington, D.C. 20202. All comments submitted in response to this notice will be available for public inspection, during and after the comment period, in Room 2085 between the hours of 8:30 a.m. and 4:00 p.m., Monday through Friday of each week except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mary Jean LeTendre, Director, Compensatory Education Programs, Office of Elementary and Secondary Education, U.S. Department of Education, 400 Maryland Avenue, SW. (Room 5102, ROB–3), Washington, D.C. 20202. Telephone: (202) 245–3081.

SUPPLEMENTARY INFORMATION: The Privacy Act of 1974 (see 5 U.S.C. 552a(e)(4)) requires the Secretary to publish in the **Federal Register** this notice of a new system of records. The Department's regulations implementing the Privacy Act of 1974 are contained in the Code of Federal Regulations (CFR) at 34 CFR Part 5b.

Chapter 1 of the ECIA provides special educational services to selected public and private school children who are educationally disadvantaged and who reside in areas in which there is a high concentration of children from low-income families. Funds are allocated on a formula basis through State educational agencies (SEAs) to local educational agencies (LEAs) that have approved applications on file with their respecitve SEAs.

Under Section 557(a) of Chapter 1, an LEA must provide services to eligible private school students that are equitable to the services provided to eligible public school students. According to Section 557(b) of Chapter 1, if an LEA is prohibited by State law or has failed to provide the required services for eligible private school students, the Secretary of Education must provide equitable services for private school students under a bypass arrangement. Normally, the Secretary selects a contractor to provide the required services under a bypass.

The Secretary has implemented Chapter 1 bypasses in certain LEAs in Missouri and Virginia, and has awarded contracts through which the services are performed. The services consist primarily of supplementary instruction in reading and mathematics to students who, based on a needs assessment, are found to be below their grade median. These services are provided and records are kept for about 2,800 students under the Missouri bypass contract and 700 students under the Virginia contract.

In order to determine the eligibility of these students, a contractor must keep a record of the scores of students on the needs assessment test. After students have been selected, records are kept of scores of tests taken upon entering the Chapter 1 program and post-test scores at the end of the program year. In addition, records are kept of grades received in the subject areas, as well as copies of progress reports from Chapter 1 teachers to regular classroom teachers and to parents of participating students. These records are essential in order to determine whether the Chapter 1 program objectives are being met and whether the private school students are receiving services comparable to those received by public school students. Individual students or their parents consent to have this information collected as a condition for their participation in the program.

Dated: May 29, 1986.

William. J. Bennett,

Secretary of Education.

The Secretary publishes notice of a new system of records to read as follows:

18–40–0077

SYSTEM NAME:

Records of Educationally Disadvantaged Students Attending Private Schools Served Through Bypass Contracts. ED/OESE/CEP.

SECURITY CLASSIFICATION:

None.

SYSTEM LOCATION:

See the Appendix to this system notice.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Selected elementary and secondary school students who—

(1) Attend private schools;

(2) Reside in target areas of bypassed local educational agencies; and

(3) Participate in the program for educationally disadvantaged students under Chapter 1 of the Education Consolidation and Improvement Act of 1981.

CATEGORIES OF RECORDS IN THE SYSTEM:

Contains documents, identified by name and number, of students participating in programs under Chapter 1 of the Education Consolidation and Improvement Act, such as pre- and post-achievement test scores, report cards, and reports from Chapter 1 teachers to regular classroom teachers and to parents.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Section 557(b), Chapter 1, Education Consolidation and Improvement Act of 1981 (Pub. L. 97–35) (20 U.S.C. 3806(b)).

PURPOSES:

The purpose of the standardized test scores obtained at the beginning of a year is to determine the eligibility of students for participation in the Chapter 1 program. The purpose of report cards and reports of Chapter 1 teachers to regular classroom teachers and to parents is to report the progress students are making during the school year. The purpose of the scores made on achievement tests given at the end of a school year is to measure the progress students have made during the year and to measure to degree to which the objectives of the Chapter 1 program have been met.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

Chapter 1 teachers make information contained in this system or records available to regular classroom teachers and to the record subjects' parents to explain to those persons the eligibility of students and their progress in the Chapter 1 program. Supervisors of the Chapter 1 teachers use information contained in this system of records as a part of the monitoring process to measure progress being made toward achieving program objectives.

The Department may disclose a record for the purposes described in the Department's Privacy Act regulations (34 CFR Part 5b, Appendix B, items (1), (3), (4), (5), (6), (8), (9), (10), and (11)).

Disclosure of information in this system of records may be made to a Congressional office from the record of an individual in response to an inquiry from the Congressional office made at the request of that individual.

In the event of litigation involving one of the parties listed below or in which one of these parties has an interest, the Department may disclose those records that it deems relevant and necessary to the Department of Justice to enable that Department to effectively represent that party, if the disclosure is compatible with the purpose for which the records were collected. The parties to which this routine use applies are—

(a) The Department, any component of the Department, or any employee of the

Department in his or her official capacity;

(b) The United States where the Department determines that the claim, if successful, is likely to directly affect the operations of the Department or any of it components; and

(c) Any Department employee in his or her individual capacity where the Department of Justice has agreed to represent such employee.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Each student's records are kept in a separate file folder. All folders are filed in locked filing cabinet in the Chapter 1 classroom. After a student no longer participates in the program, his or her records are transferred to the contractor's office where they are stored in locked filing cabinets.

RETRIEVABILITY:

The records are indexed by the name and identification number of students participating in the Chapter 1 program.

SAFEGUARDS:

The records are secured in a locked filing cabinet. The key is kept by the Chapter 1 teacher. After a student no longer participates in the program, the records are transferred to the contractor's office where they are stored in a locked filing cabinet. Direct access is restricted to the Chapter 1 teacher and aide during the day-to-day program operation. The instructional supervisor, representatives of the contractor, and Department of Education staff have access during monitoring visits.

RETENTION AND DISPOSAL:

Records are maintained in the contractor's office for at least three years after final payment on the contract. Disposal of records follows the requirements of the Federal Records Disposal Act.

SYSTEM MANAGER AND ADDRESS:

Director, Compensatory Education Programs, U.S. Department of Education, 400 Maryland Avenue, SW (Room 5102, ROB-3), Washington, D.C. 20202.

NOTIFICATION PROCEDURE:

For information about a student in a program in a bypassed local educational agency in a State listed in the Appendix to this notice, the student or his or her parent or guardian (authorized individual) must notify the appropriate contractor for the State served by the bypass contract. The Appendix to this notice provides the name and address of the appropriate contractor.

For identification, the authorized individual seeking information should provide the name, home address, and school of the student for whom information is being requested. The request must meet the requirements in the Department's Privacy Act regulations at 34 CFR 5b.5.

RECORD ACCESS PROCEDURES:

An authorized individual must contact the appropriate contractor to obtain bypass information about a student who is or has been in a bypass program.

The authorized individual should provide the appropriate contractor with information listed in the notification procedure of this notice and reasonably specify the record contents being sought. If the authorized individual is unable to obtain satisfaction from the contractor, he or she may seek access through the system manager. The request must meet the requirements of the Department's Privacy Act regulations at 34 CFR 5b.5.

CONTESTING RECORD PROCEDURES:

An authorized individual who wishes to contest the content of the record of a participating Chapter 1 student should contact the appropriate contractor for the State served by the bypass contract. See the Appendix to this notice for the name and address of the appropriate contractor. The authorized individual should identify himself or herself and state, in writing, which portion of the record the individual desires changed and provide a justification and authorization for the change. The appropriate contractor will forward the request to the system manager. The request must meet the requirements of 34 CFR 5b.7.

RECORD SOURCE CATAGORIES:

The contractor obtains test score information from public and private schools where achievement tests for program eligibility are administered, and obtains class performance information from Chapter 1 teachers.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

Appendix to System 18-40-0077

State served under the Bypass Contract:

Missouri

Contractor serving the State:

Blue Hills Homes Corporation, 1020 East 63rd Street, Kansas City, MO 64110

Sites served by the contractor:

801 Locust Street, Apt. 26, Boonville, MO 65233
Clinton Civic Center, Third and Green Streets, Clinton, MO 64501
The Body Shop, 908 Bernadette Drive, Columbia, MO 65202
1122 Cost McCarty, Jefferson City, MO 65101
Linwood YMCA, 3800 East Linwood Street, Kansas City, MO 64128
Della C. Lamb Center, 500 Woodland Street, Kansas City, MO 64124
W.E.B. Dubois Learning Center, 5501 Cleveland Street, Kansas City, MO 64130
Mid American Bank of Linn, Linn, MO 65051
Arrow Street Office Building, 368 West Arrow Street, Marshall, MO 65340
Greenco Credit Union, 802 Breckinridge Street, Mexico, MO 65265
Sedalia Community Center, 314 South Washington Avenue, Sedalia, MO 65301
Springfield Community Center, 618 North Benton Street, Springfield, MO 65802
Tipton Rentals Center, P.O. Box 458, Tipton, MO 65081
University of Missouri Meeting Room, P.O. Box 187, Vienna, MO 65582
Rich Fountain Senior Citizens Housing Project Meeting Room, Rt. #1, Freeburg, MO 65035
Westphalia Tour Council Building, P.O. Box 85, Westphalia, MO 65085
Freeburg Fire House Building, Rt. #1, P.O. Box 27, Freeburg, MO 65035
The Florist Shop, 28 North Pacific Street, Cape Girardeau, MO 63701
The Public Library, 225 South High Street, Jackson, MO 63755
Box 65, Monroe, MO 63456
The Bine Apartment, 719 Bine Street, Poplar Bluff, MO 63901
360 A. Market Street St. Genevieve, MO 63670
Baden Center, 8230 North Broadway Street, St. Louis, MO 63147
Carr Lane Center, 1004 North Jefferson Avenue, St. Louis, 63106
Castleman Center, 2004 South 39th Street, St. Louis, 63110
Cherokee Center, 3200 South Jefferson Avenue, St. Louis, MO 63118
Dunn-Marquette Center, 4025 Minnesota Avenue, St. Louis, MO 63118
Fanning Center, 3417 Grace Avenue, St. Louis, MO 63116
Gardenville Center, 6651 Cravois Avenue, St. Louis, MO 63116
Kennard Center, 5031 Potomac Street, St. Louis, MO 63139
Lafayette Center, 2353 Park Avenue, St. Louis, MO 63104
Lowell Center, 1409 Linton Avenue, St. Louis, MO 63107
Natural Bridge Center, 6814 Natural Bridge Road, St. Louis, MO 63121
Wilmington Center, 5914 Leona Avenue, St. Louis, MO 63130
Candy Center, 4206 Kennerly Avenue, St. Louis, MO 53113
12th and Park Center, 1410 South 12th Street, St. Louis, MO 63104
Windsor Center, 4092 Robert Avenue, St. Louis, MO 63116
Wahl Center, 1515 North Kingshighway Boulevard, St. Louis, MO 63113

Records are also located in mobile units at various public sites in local school districts. Access to these records can be obtained by writing to the contractor:

Blue Hills Homes Corporation, 1020 East 63rd Street, Kansas City, MO 64110

Appendix to System 18-40-0077

State served under the Bypass Contract:

Virginia

Contractor serving the State:

NonPublic Educational Services, Inc., 4733 Bethesda Avenue, Suite 725, Bethesda, MD 20814

Sites served by the contractor:

Buckingham Village, Apt. 4, 221 N. Thomas Street, Arlington, VA 22203
St. Gabriel's Day Care Center, 4319 Sano Street, Alexandria, VA 22312
Education Center, 3301 Glen Carolyn Road, Falls Church, VA 22041
Little House, Spring & Broad Street, Falls Church, VA 22041
Hartwood House, 2903 Popkins Lane, Alexandria, VA 22306
McGurk House, 2425 Tate Spring Road, Lynchburg, VA 23505
Grace Street Apartment, 2508 East Grace Street, Richmond, VA 23223
Brick Learning Center, 3100 A Grove Avenue, Richmond, VA 23221
Carmel Center Nursery, 52 Harpersville Road, Newport News, VA 23601
Southside Day Nursery, 1420 McDough Street, Richmond, VA 23224
Lewis Ginter Recreation Association, 3421 Hawthorn Avenue, Richmond, VA 23222
Bartleby's, 412 Libbie Avenue, Richmond, VA 23226
Knights of Columbia, 211 West Government Avenue, Norfolk, VA 23503
St. Gregory's Credit Union, 5347 Virginia Beach Boulevard, Virginia Beach, VA 23461
Salvation Army, 2306 Airline Boulevard, Portsmouth, VA 23701
Boy Scout Building, 3341 Tidewater Drive, Norfolk, VA 23509
Artic Crescent, Apt. 3A, 317 15th Street, Virginia Beach, VA 23451
St. Mary's Infant Home, 317 Chapel Street, Norfolk, VA 23504
Thunderbird Bowling Lanes, 1577 Laskin Road, Virginia Beach, VA 23454
3407 Colly Avenue, Norfolk, VA 23508
Scout Building, 7813 Holprin Drive, Norfolk, VA 23518

[FR Doc. 86-12453 Filed 6-2-86; 8:45 am]
BILLING CODE 4000-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP81-244-004]

Consolidated Gas Transmission Corp. and National Fuel Gas Supply Corp.; Notice of Petition To Amend

May 21, 1986.

Take notice that on April 30, 1986, National Fuel Gas Supply Corporation (National), Ten Lafayette Square, Buffalo, New York 14203, and Consolidated Gas Transmission Corporation (Consolidated), 445 West Main Street, Clarksburg, West Virginia 26301, filed in Docket No. CP81-244-004 a joint petition to amend a certificate of public convenience and necessity authorizing the exchange of natural gas between National and Consolidated so as to expand the area of interest designated by the outstanding certificate issued October 26, 1981, all as more fully set forth in the petition to amend which is on file with the Commission and open to public inspection.

Petitioners state that an existing certificate authorizes them to exchange gas at various points of interconnection within a designated area of interest which includes Elk, Cameron and Clearfield Counties in Pennsylvania, and Erie and Steuben Counties in New York. Petitioners are now requesting authorization to expand the designated area of interest to include Allegany County, New York. Petitioners state that such authorization would provide an additional outlet for gas produced by National from its wells in Allegany County, and would thereby improve recovery of National's reserves.

Petitioners state that they would notify the Commission of additional exchange points in Allegany County in their annual filing showing additions and deletions from the exchange agreement and that any jurisdictional facilities necessary to effect the exchange of gas from new exchange points would be constructed under § 157.208 of the Commission's Regulations.

Any person desiring to be heard or to make any protest with reference to said petition to amend should on or before June 11, 1986, file with the Federal Regulatory Commission, Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with with Commission's Rules.

Kenneth F. Plumb,

Secretary.

[FR Doc. 85-12397 Filed 6-2-86; 8:45 am]
BILLING CODE 6717-01-M

[Docket No. CP83-498-003]

The Inland Gas Co., Inc.; Proposed Change in FERC Gas Tariff

May 29, 1986.

Take notice that The Inland Gas Company, Inc. (Inland) on May 15, 1986 tendered for filing proposed First Revised Sheet No. 10 to its FERC Gas Tariff, First Revised Volume No. 1. Said tariff sheet bears an issue date of May 15, 1986 and an effective date of July 1, 1986. The sheet was amended on 5-21-86.

Inland states that the foregoing tariff sheet is being filed pursuant to the Commission's Order issued August 21, 1984 approving a Stipulation and Agreement in the above-captioned dockets. Inland further states that the subject tariff sets forth a proposed transportation rate, plus retainage, to be effective July 1, 1986.

A copy of Inland's tariff filing was served upon each of its affected customers. Also, a copy of Inland's tariff filing is available for public inspection during regular business hours in its offices at 336-338 Fourteenth Street, Ashland, Kentucky 41101.

Any person desiring to be heard or to protest should file a motion to intervene or protest with the Federal Energy Regulatory Commission, Union Center Plaza Building, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's rules of practice and procedure. All such motions or protests should be filed on or before June 5, 1986. Protests will be considered by the Commission in determining the appropriate action to be taken but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of Inland's tariff and the proposed revision are on file with the Commission and are available for public inspection.

Kenneth E. Plumb,

Secretary.

[FR Doc. 86-12403 Filed 6-2-86; 8:45 am]
BILLING CODE 6717-01-M

[Docket No. CP85-775-001]

Northern Natural Gas Co., Division of InterNorth, Inc.; Application Amendment

May 21, 1986.

Take notice that on May 8, 1986, Northern Natural Gas Company,

Division of InterNorth, Inc., (Northern), 2223 Dodge Street, Omaha, Nebraska 68102, filed in Docket No. CP85–775–001, an amendment to its application filed in Docket No. CP85–775–000 pursuant to section 7(c) of the Natural Gas Act, for authority to implement, on October 27, 1985, proposed adjustments to the firm entitlements of certain of Northern's market area utility customers, as more fully set forth in the amendment which is on file with the Commission and open to public inspection.

Northern indicates that in its original application, it proposed to effectuate on November 27, 1985, certain adjustments to the firm entitlements of its market area utility customers pursuant to a stipulation and agreement of settlement filed in resolution of issues in Docket Nos RP82–71, TA83–1–59, TA84–1–59, and TA85–1–59 (RP82–71 stipulation and agreement). Northern states that, subsequently, the Commission remanded the RP82–71 stipulation and agreement to the administrative law judge as to all participants for the purpose of developing a record upon which a decision on the contested issues regarding the offer of settlement may reasonably be based.

Northern indicates it has agreed in its stipulation and agreement of settlement filed in resolution of issues in Docket No. RP85–206 (RP85–206 stipulation and agreement) to implement on October 27, 1985, the changes in firm entitlements requested herein. Consequently, in view of the remand of the RP82–71 stipulation and agreement and the agreement reached in the RP85–206 stipulation and agreement, Northern is amending the effective date of the proposed adjustments in firm entitlements from November 27, 1985, to October 27, 1985.

Any person desiring to be heard or to make any protest with reference to said petition to amend should on or before June 11, 1986, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's rules of practice and procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules. Persons who have heretofore filed need not file again.

Kenneth F. Plumb,

Secretary.

[FR Doc. 86–12401 Filed 6–2–86; 8:45 am]

BILLING CODE 6717–01–M

[Docket No. TA86–3–41–003]

Southwest Gas Corp.; Compliance Filing

May 23, 1986.

Take notice that on May 12, 1986, Southwest Gas Corporation (Southwest) tendered for filing Substitute Sixth Revised Sheet No. 31 to its FERC Gas Tariff, Original Volume No. 1. According to § 381.103(b)(2)(iii) of the Commission's regulations (18 CFR 381.103(b)(2)(iii)), the date of filing is the date on which the Commission receives the appropriate filing fee, which in the instant case was not until May 19, 1986.

Southwest states that the revised language on the tariff sheet clarifies the methodology for calculating the surcharge adjustment.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 214 and 211 of the Commission's Rules of Practice and Procedure (18 CFR 385.214, 385.211). All such motions or protests should be filed on or before June 5, 1986. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 86–12398 Filed 6–2–86; 8:45 am]

BILLING CODE 6717–01–M

[Docket No. TA86–4–17–000, 001]

Texas Eastern Transmission Corp.; Proposed Changes in FERC Gas Tariff

May 29, 1986.

Take notice that Texas Eastern Transmission Corporation (Texas Eastern) on May 22, 1986, tendered for filing as a part of its FERC Gas Tariff, Fourth Revised Volume No. 1, six copies each of the following tariff sheets:

Seventy-ninth Revised Sheet No. 14
Seventy-ninth Revised Sheet No. 14A
Seventy-ninth Revised Sheet No. 14B
Seventy-ninth Revised Sheet No. 14C
Seventy-ninth Revised Sheet No. 14D

The above tariff sheets are being issued to reflect in Texas Eastern's rates the impact of Texas Eastern's latest exercise of "market-out" provisions in certain of its gas purchase contracts. Texas Eastern has exercised such market-out provisions to reduce the price under those certain gas purchase contracts to $1.85 mmbtu plus taxes effective June 1, 1986.

On March 13, 1986, Texas Eastern filed an out-of-cycle PGA decrease to be effective April 1, 1986. That filing reflected the impact of Texas Eastern's exercising market-out provisions in certain supplier contracts to a level of $2.25 per mmbtu plus taxes effective April 1, 1986. The March 13, 1986 filing was based upon the current cost of gas adjustment and surcharge adjustment effective as a result of Texas Eastern's regular semiannual PGA tracking filing of February 1, 1986, adjusted only to reflect the impact on the cost of gas adjustment of the cost reduction resulting from Texas Eastern's exercise of market-out provisions effective April 1, 1986. The above-listed tariff sheets are based upon the March 13, 1986 filing, adjusted only to reflect the impact on the cost of gas adjustment of the cost reduction resulting from Texas Eastern's exercise of market-out provisions effective June 1, 1986. The impact of Texas Eastern's rates of the instant proposal is a reduction of $.2092/dth in the commodity component of Texas Eastern's sales rates.

The above tariff sheets also reflect the Contract Adjustment Demand rates being filed almost concurrently herewith in Docket No. RP86–61–000 in compliance with the Commission's directive in its Order Accepting Tariff Sheets Subject To Conditions, issued May 7, 1986 in Docket RP86–61–000.

The proposed effective date of the above tariff sheets in June 1, 1986.

Texas Eastern respectfully requests waiver of the provisions of its tariff and any Regulations that the Commission may deem necessary to accept the above tariff sheets to be effective on June 1, 1986, coincidently with the effectiveness of Texas Eastern's exercise of market-out provisions, consistent with prior waiver orders by the Commission for such out-of-time market-out PGA rate reductions.

Copies of the filing were served on Texas Eastern's jurisdictional customers and interested state commissions. Any person desiring to be heard or to protest said filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 825

North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's rules of practice and procedure. All such motions or protests should be filed on or before June 5, 1986. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 86-12404 Filed 6-2-86; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP86-8-001]

Transwestern Pipeline Co.; Filing

May 29, 1986.

Take notice that on May 1, 1986, Transwestern Pipeline Company (Transwestern) tendered for filing the following schedules pursuant to the Commission's order issued December 12, 1985, approving Transwestern's October 31, 1985 request that it be permitted to direct bill its jursidictional customers over two successive six-month periods for retroactive production-related costs (Order 94 costs) paid to its suppliers. These schedules set forth the calculations by customer of the amounts to be direct billed for the second six-month period.

Schedule A

By production month the Order 94 amount paid to producers subsequent to September 30, 1985.

Schedule B

The actual sales by month to each customer.

Schedule C

Each customer's applicable percentage of sales by month.

Schedule D

The allocated Order 94 costs by customer for each month.

Transwestern states that in the event it makes additional payments for retroactive Order 94 costs, it will file within 15 days of each monthly billing the information required under § 271.104(f) of the Commission's regulations and the relevant contract provisions supporting the billed costs.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 214 and 211 of the Commission's Rules of Practice and Procedure. All such motions or protests should be filed on or before June 5, 1986. (18 CFR 385.214, 385.211). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb

Secretary.

[FR Doc. 86-12399 Filed 6-2-86; 8:45 am]

BILLING CODE 6717-01

[Docket No. TA86-2-35-003]

West Texas Gas, Inc.; Tariff Filing and Petition for Waiver or, in the Alternative, for Clarification of Commission Regulations

May 29, 1986.

Take notice that on May 22, 1986, West Texas Gas, Inc. (WTG) filed a Petition for Waiver or, in the Alternative, for Clarification Of Commission Regulations. Specifically, WTG seeks a determination that § 381.205 of the Commission's regulations, 18 CFR 381.205 (1986), does not require a filing fee to be paid for the submission of a revised tariff sheet complying with and conforming to provisions of a Commission order in which a proposed tariff change has been reviewed and conditionally accepted.

This petition is in regard to WTG's filing of May 8, 1986 of Sixth Revised Sheet No. 3a, to its FERC Gas Tariff, Original Volume 1. The revised tariff sheet was submitted in accordance with the Commission's order issued May 7, 1986, in Docket No. TA86-2-35-000. The Commission notified WTG that its May 8, 1986, filing was deficient because it was not accompanied by the filing fee. By letter dated May 19, 1986, the Commission's Secretary notified WTG that the applicable fee or a petition for waiver must be submitted by May 28, 1986.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 825 North Capitol Street, NE., Washington, DC 20426, in accordance with Rules 214 and 211 of the Commission's Rules of Practice and Procedure. (18 CFR 385.214, 385.211). All such motions or protests should be filed on or before June 5, 1986. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 86-12400 Filed 6-2-86; 8:45 am]

BILLING CODE 6717-01-M

ENVIRONMENTAL PROTECTION AGENCY

[FRL-3023-9]

Agency Information Collection Activities Under OMB Review

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: Section 3507(a)(2)(B) of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*) requires the Agency to publish in the **Federal Register** a notice of proposed information collection requests (ICRs) that have been forwarded to the Office of Management and Budget (OMB) for review. The ICR describes the nature of the solicitation and the expected impact, and where appropriate includes the actual data collection instrument. The following ICR is available for review and comment.

FOR FURTHER INFORMATION CONTACT: Nanette Liepman, (202) 382-2740 or FTS 382-2740.

SUPPLEMENTARY INFORMATION:

Office of Pesticides and Toxic Substances

Title: Chemical Imports and Exports; Section 12(b) Notification of Exports (EPA ICR #0795). (This is an extension of a previously approved ICR; the estimated number of respondents has gone up from fifty in the last ICR to eighty-five in the present one because of a projected increase in the number of chemicals subject to testing; otherwise, there is no change.)

Abstract: This information collection implements section 12(b) of the Toxic Substances Control Act (TSCA), and applies to exporters of chemical substances that are the subject of regulatory actions under certain other sections of TSCA. For each foreign country to which an exporter sends such a chemical, the exporter must report to EPA the first export each year of the

chemical to that country. The information is used to notify foreign governments of EPA actions with respect to the substances.

Respondents: Certain exporters of chemical substances.

Office of Solid Waste and Emergency Response

Title: Final Authorization for Hazardous Waste Management Programs (EPA ICR #0969). (This is a renewal of a previously approved ICR; there are no changes.)

Abstract: States seeking to receive interim or final authorization under RCRA to administer and enforce their hazardous waste management programs in lieu of the Federal program may submit an application to EPA. The information submitted should demonstrate that the State program is equivalent to the Federal program for a final authorization, or substantially equivalent for an interim authorization.

Respondents: States.

Agency PRA Clearance Requests Completed by OMB

EPA ICR #0097, Unleaded Gasoline Inspection and State I Vapor Recovery, was approved 5/12/86 (OMB #2060–0009; expires 5/31/89).

EPA ICR #0267, Report of Pollution-Caused Fish Kill, was approved 5/2/86 (OMB #2040–0087; expires 5/31/89).

EPA ICR #0064, New Source Performance Standards (NSPS) for Bulk Gasoline Terminals, was approved 5/2/86 (OMB #2060–0006; expires 5/31/89).

EPA ICR #1056, New Source Performance Standards (NSPS) for Emission Monitoring for Nitric Acid Plants, was approved 5/9/86, (OMB #2060–0019; expires 5/31/88).

EPA ICR #1067, Recordkeeping and Reporting for Primary Aluminum Reduction Plants (NSPS Subpart S), was approved 5/9/86 (OMB #2060–0031; expires 5/31/89).

EPA ICR #1071, New Source Performance Standards (NSPS) for Gas Turbines (Subpart GG)—Information Requirements, was approved 5/9/86 (OMB #2060–0028; expires 5/31/88).

EPA ICR #1292, Proposed Rule Regarding the Sale and Use of Aftermarket Converters, was approved 5/12/86 (OMB #2060–0135; expires 5/31/89).

Comments on all parts of this notice may be sent to:

Nanette Liepman, U.S. Environmental Protection Agency, Office of Standards and Regulations (PM–223), Information and Regulatory Systems Division, 401 M Street, SW., Washington, DC 20460

and

Carlos Tellez, Office of Management and Budget, Office of Information and Regulatory Affairs, New Executive Office Building (Room 3228), 726 Jackson Place, NW., Washington, DC 20503.

Dated: May 28, 1986.

Daniel J. Fiorino,

Acting Director, Information and Regulatory Systems Division.

[FR Doc. 86–12382 Filed 6–2–86; 8:45 am]

BILLING CODE 6560–50–M

[OPTS–51621; FRL–3012–5]

Certain Chemicals Premanufacture Notices

Correction

In FR Doc. 86–10015 beginning on page 16587 in the issue of Monday, May 5, 1986, make the following corrections:

On page 16588, in the second column, under **P 86–937**, the second and third lines should read:

Chemical. (G) Alkyl formamide.

Use/Production. (G) Industrial lubricant additive. Prod. range: Confidential.

BILLING CODE 1505–01–M

FEDERAL COMMUNICATIONS COMMISSION

Public Information Collection Requirement Submitted To Office of Management and Budget for Review.

May 27, 1986.

The Federal Communications Commission has submitted the following information collection requirement to OMB for review and clearance under the Paperwork Reduction Act of 1980, Pub. L. 96–511.

Copies of this submission are available from Doris Benz, FCC, (202) 632–7513. Comments should be sent to David Reed, Office of Management and Budget, Room 3235, NEOB, Washington, DC 20503 (202) 395–7231.

OMB NO.: 3060–0010

Form No.: FCC 323

Title: Ownership Report

Action: Revision

Estimated Annual Burden: 3,085 Responses; 21,595 Hours.

Federal Communications Commission.

William J. Tricarico,

Secretary.

[FR Doc. 86–12340 Filed 6–2–86; 8:45 am]

BILLING CODE 6712–01–M

Study Group B of the U.S. Organization for the International Telegraph and Telephone Consultative Committee (CCITT); Meeting

May 22, 1986.

Study Group B of the U.S. Organization for the International Telegraph and Telephone Consultative Committee (CCITT) will meet on June 11, 1986 at 10:00 a.m. in Room 856, Federal Communications Commission, 1919 M Street, NW., Washington, DC. This Study Group deals with prepartions for the 1988 World Administrative Telegraph and Telephone Conference (PC/WATTC).

The purpose of the meeting is to prepare for the upcoming preparatory Study Group meeting for PC/WATTC, tentatively scheduled for December 1986, in Geneva.

Members of the general public may attend the meeting and join in the discussion, subject to the instructions of the Co-Chairman. Admittance of public members will be limited to the seating available.

For further information, please contact Mr. Wendell Harris, Federal Communications Commission; telephone (202) 632–3214 or Mr. Phil Onstad, Control Data Corporation; telephone (202) 789–6784.

Federal Communications Commission.

William J. Tricarico,

Secretary.

[FR Doc. 86–12341 Filed 6–2–86; 8:45 am]

BILLING CODE 6712–01–M

FEDERAL MARITIME COMMISSION

Agreement(s) Filed

The Federal Maritime Commission hereby gives notice of the filing of the following agreement(s) pursuant to section 5 of the Shipping Act of 1984.

Interested parties may inspect and obtain a copy of each agreement at the Washington, DC Office of the Federal Maritime Commission, 1100 L Street, NW., Room 10325. Interested parties may submit comments on each agreement to the Secretary, Federal Maritime Commission, Washington, DC 20573 within 10 days after the date of the **Federal Register** in which this notice appears. The requirements for

comments are found in section 572.603 of Title 46 of the Code of Federal Regulations. Interested persons should consult this section before communicating with the Commission regarding a pending agreement.

Agreement No.: 202–003103–086.

Title: Japan-Atlantic and Gulf Freight Conference.

Parties:

Barber Blue Sea Line
Japan Line. Ltd.
Kawasaki Kisen Kaisha, Ltd.
Mitsui O.S.K. Lines, Ltd.
A.P. Moller-Maersk Line
Neptune Orient Lines Limited
Nippon Yusen Kaisha
Orient Overseas Container Line, Inc.
United States Lines, Inc.
Yamashita-Shinnihon Steamship Co., Ltd.

Synopsis: The proposed amendment would permit the parties to disassociate from Conference actions taken to reduce rates on intermodal cargo or to publish new intermodal points until a conference intermodal tariff is filed. The parties have requested a shortened review period.

Agreement No.: 224–010644–002.

Title: Lost Angeles Terminal Agreement.

Parties:

City of Lost Angeles
Indies Terminal Company (Indies)

Synopsis: The proposed amendment would increase the size of the Indies permises by approximately 11.66 acres to permit Indies to serve Yang Ming Marine Transport, Ltd. (Yang Ming). The amendment would also provide for changes in the computation of revenue sharing breakpoints and tonnage handling guarantees to reflect Yang Ming's presence.

Agreement No.: 202–010950.

Title: Aruba Bonaire Curacao Liner Association.

Parties:

Genesis Container Line Ltd.
Sea-Land, Service, Inc.
King Ocean Service de Venezuela S.A.

Synopsis: The proposed agreement would establish a rate-making arrangement between the parties in the trade between U.S. Atlantic and Gulf Ports and ports in Aruba, Bonaire and Curacao and inland points via such ports. The parties have requested a shortened review period.

By Order of the Federal Maritime Commission.

Dated: May 29, 1986.

Tony P. Kominothy,

Assistant Secretary.

[FR Doc. 86–12418 Filed 6–2–86; 8:45 am]

BILLING CODE 6730–01–M

FEDERAL RESERVE SYSTEM

Federal Open Market Committee; Domestic Policy Directive of April 1, 1986

In accordance with section 217.5 of its rules regarding availability of information, there is set forth below the Committee's Policy Directive issued at its meeting held on April 1, 1986.[1] The following domestic policy directive was issued to the Federal Reserve Bank of New York:

The information reviewed at this meeting indicates a mixed pattern of development with evidence of a pickup in economic activity from the reduced fourthquarter pace but with spending sluggish in some key sectors. Total nonfarm payroll employment increased appreciably further in February following a large rise in January, but employment in manufacturing fell after four months of gains and industrial production declined. The civilian unemployment rate rose sharply to 7.3 percent. Retail sales were little changed in January and February after rising over the previous two months, while housing starts were well above their pace in late 1985. Business capital spending apparently weakened somewhat in early 1986. The merchandise trade deficit for January appears to have been only slightly smaller than in December; preliminary data for February suggest that exports increased and that the price and quantity of oil imports declined. Largely reflecting declines in energy prices, consumer prices edged down on balance over the first two moths of 1986 and producer prices fell substantially.

Growth in M1 picked up considerably over the course of the first quarter, leaving this aggregate by March somewhat above the upper end of its range for the year. On the other hand, growth of M2 was generally sluggish over the past 3 months and was running below its long-run range. Expansion of M3 was moderate during the winter months, with growth around the midpoint of its range for 1986. Interest rates have declined considerably since the Febraury meeting of the Committee. On March 6, the Federal Reserve Board approved a reduction in the discount rate from 7–1/2 to 7 percent. The trade-weighted value of the dollar against major foreign currencies continued to decline through mid-March but has risen somewhat more recently; on balance the dollar has declined slightly since the February meeting.

The Federal Open Market Committee seeks monetary and financial conditions that will foster reasonable price stability over time, promote growth in output on a sustainable basis, and contribute to an inproved pattern of international transactions. In furtherance of these objective the Committee agreed at its February meeting to establish the following ranges for monetary growth, measured from the fourth quarter of 1985 to the fourth quarter of 1986. With respect to M1, the Committee recognized that, based on the experience of recent years, the behavior of that aggregate was subject to substantial uncertainties in relationship to economic activity and prices, depending among other things on its responsiveness to changes in interest rates. It agreed that an appropriate target range under existing circumstances would be 3 to 8 percent, but it intends to evaluate movements in M1 in the light of its consistency with the other monetary aggregates, developments in the economy and financial markets, and potential inflationary pressures. It adopted a range of 6 to 9 percent for M2 and 6 to 9 percent for M3. The associated range for growth in total domestic nonfinanciaL debt was set at 8 to 11 percent for the year 1986.

In the implementation of policy for the immediate future, the Committee seeks to maintain the existing degree of pressure on reserve positions. This action is expected to be consistent with growth in M2 and M3 over the period from March to June at annual rates of about 7 percent; while the behavior of M1 continues to be subject to unusual uncertainty, growth at an annual rate of about 7 to 8 percent over the period is anticipated. Somewhat lesser reserve restraint or somewhat greater reserve restraint might be acceptable depending on behavior of the aggregate, the strength of the business expansion, developments in foreign exchange markets, progress against inflation, and conditions in domestic and international credit markets. The Chairman may call for Committee consultation if it appears to the Manager for Domestic Operations that reserve conditions during the period before the next meeting are likely to be associated with a federal funds rate persistently outside a range of 6 to 10 percent.

Votes for this action: Messrs. Volcker, Corrigan, Angell, Guffey, Horn, Johnson, Melzer, Morris, Rice, Ms. Seger, and Mr. Wallich. Votes against this action: None. Absent and not voting: Mr. Martin.

By order of the Federal Open Market Committee, May 29, 1986.

Stephen H. Axilrod,

Secretary.

[FR Doc. 86–12458 Filed 6–2–86; 8:45 am]

BILLING CODE 6210–01–M

[1] The Record of policy actions of the Committee for the meeting of April 1, 1986, is filed as part of the original document. Copies are available upon request to The Board of Governors of the Federal Reserve System, Washington, DC 20551.

Citizens Financial Group, Inc.; Formation of, Acquisition by, or Merger of Bank Holding Companies

The company listed in this notice has applied for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C. 1842) and § 225.14 of the Board's Regulation Y (12 CFR 225.24) to become a bank holding company or to acquire a bank or bank holding company. The factors that are considered in acting on the applications are set forth in section 3(c) of the Act (12 U.S.C. 1842(c)).

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that application or to the offices of the Board of Governors. Any comment on an application that requests a hearing must include a statement of why a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute and summarizing the evidence that would be presented at a hearing.

Comments regarding this application must be received not later than June 26, 1986.

A. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Citizens Financial Group, Inc.*, Toluca, Illinois; to become a bank holding company by acquiring 100 percent of the voting shares of The Citizens National Bank of Toluca, Toluca, Illinois.

Board of Governors of the Federal Reserve System, May 28, 1986.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 86-12317 Filed 6-2-86; 8:45 am]

BILLING CODE 6210-01-M

U.S. Trust Corp., et al.; Acquisitions of Companies Engaged in Permissible Nonbanking Activities

The organizations listed in this notice have applied under § 225.23(a)(2) of (f) of the Board's Regulation Y (12 CFR 225.23(a)(2) or (f)) for the Board's approval under section 4(c)(8)) of the bank holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to acquire or control voting securities or assets of a company engaged in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweight possible adverse effects, such as undue concentration of resources, decreased on unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated for the application or the offices of the Board of Governors not later than June 16, 1986.

A. **Federal Reserve Bank of New York** (A. Marshall Puckett, Vice President) 33 Liberty Street, New York, New York 10045:

1. *U.S. Trust Corporation*, New York, New York; to acquire Advanced Information Management, Inc., Boston, Massachusetts, and New York, New York, and thereby engage in licensing software and providing services to others relating to individual retirement account record keeping, mutual fund shareholder accounting and other data processing and data transmission services and facilities (including data processing and data transmission hardware, software, documention and operation personnel) or access to such services or facilities by any technologically feasible means for financial, banking, and economic data.

B. **Federal Reserve Bank of Cleve land** (Lee S. Adams, Vice President) 1455 East Sixth Street, Cleveland, Ohio 44101:

1. *AmeriTrust Corporation*, Cleveland, Ohio; to acquire certain assets of Associates Corporation of North America and its wholly-owned subsidiary, Associates Commercial Corporation, and thereby engage in the business of making and servicing loans in accordance with § 225.25(b)(1) of the Board's Regulation Y. This activity will be conducted from offices in Boston, Massachusetts; Chicago, Illinois; Dallas, Texas; North Charleston, South Carolina; and Philadelphia, Pennsylvania.

Board of Governors of the Federal Reserve System, May 28, 1986.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 86-12318 Filed 6-2-86; 8:45 am]

BILLING CODE 6210-01-M

Viejo Bancorp; Application To Engage de Novo in Permissible Nonbanking Activities

The company listed in this notice has filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commerce or to engage de novo, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether consummation of the proposal can "reasonably be expected to produce benefits to the public, such as greater convenience, increased competition, or gains in efficiency, that outweigh possible adverse effects, such as undue concentration of resources, decreased or unfair competition, conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Unless otherwise noted, comments regarding the application must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than June 19, 1986.

A. **Federal Reserve Bank of San Francisco** (Harry W. Green, Vice President), 101 Market Street, San Francisco, California 94105:

1. *Viejo Bancorp*, Mission Viejo, California; to engage de novo through its subsidiary, Viejo Escrow Corporation, Mission Viejo, California, in the functions or activities that may be performed by a trust company pursuant to § 225.25(b)(3) of the Board's Regulation Y. These activities will be conducted only in the state of California.

Board of Governors of the Federal Reserve System, May 28, 1986.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 86-12319 Filed 6-2-86; 8:45 am]

BILLING CODE 6210-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 85D-0541]

Effectiveness Requirements and Good Manufacturing Requirements of New Animal Drugs Used in Free-Choice Feeds; Availability of Draft Guidelines

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of two draft guidelines; one entitled "Guidelines for Evaluation of Effectiveness of New Animal Drugs for Use in Free-Choice Feeds," and the other entitled "Medicated Free-Choice Feeds" covering good manufacturing practice concerning such products. These draft guidelines are intended to replace the current "Cattle Medicated Block Guidelines." In a separate document published elsewhere in this issue of the **Federal Register**, FDA is amending the animal drug regulations covering the requirements for approval of applications for medicated free-choice feed products.

ADDRESSES: The draft guidelines are available for public examination at, and written comments may be submitted to, the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857. Requests for copies of the draft guidelines may be submitted to the Division of Biometrics and Production Drugs (HFV-120), Center for Veterinary Medicine, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Richard P. Lehmann, Center for Veterinary Medicine (HFV-120), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301-443-3134.

SUPPLEMENTARY INFORMATION: These draft guidelines are intended to furnish guidance to sponsors of applications for and manufacturers of free-choice products covered by the final rule published elsewhere in this issue of the **Federal Register.** The final rule contains background information concerning FDA's regulation of such products.

This notice of availability is issued under 21 CFR 10.90(b), which provides for use of guidelines to establish procedures of general applicability that are not legal requirements but are acceptable to the agency. Sponsors and manufacturers may rely upon a guideline with the assurance that it represents procedures acceptable to the agency (see 21 CFR 10.90). If such persons believe that alternative procedures are also applicable, a guideline does not preclude them from pursuing the alternative procedures. Under such circumstances, however, the agency encourages sponsors and manufacturers to discuss the alternative procedures in advance with FDA to prevent the expenditure of money and effort for work that may later be found to be unacceptable.

Interested persons may, at any time, submit written comments on the guidelines to the Dockets Management Branch. Such comments will be considered in determining if revisions of the guidelines are required. Respondents should submit two copies (except that individuals may submit single copies) identified with the docket number found in brackets in the heading of this document. Received coments may be seen in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: May 13, 1986.

Joseph P. Hile,

Associate Commissioner for Regulatory Affairs.

[FR Doc. 86-12347 Filed 6-2-86; 8:45 am]

BILLING CODE 4160-01-M

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Meetings

Pursuant to Pub. L. 92-463, notice is hereby given of the meetings of committees of the National Institute of Allergy and Infectious Diseases for June, 1986.

These meetings will be open to the public to discuss administrative details relating to committee business and for program review. Attendance by the public will be limited to space available. Portions of these meetings will be closed to the public in accordance with provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code, and section 10(d) of Pub. L. 92-463, for the review, discussion, and evaluation of individual grant applications and contract proposals. These applications, proposals, and the discussions could reveal confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the applications and proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Ms. Patricia Randall, Office of Research Reporting and Public Response, National Institute of Allergy and Infectious Diseases, Building 31, Room 7A-32, National Institutes of Health, Bethesda, Maryland 20892, telephone (301) 496-5717, will provide summaries of the meetings and rosters of the committees members upon request.

Substantive program information may be obtained from the Executive Secretary whose name, room number, and telephone number are listed below each committee.

Name of committee: Allergy and Clinical Immunology Subcommittee of the Allergy, Immunology, Transplantation Research Committee.

Executive secretary: Dr. Nirmal Das, Room 706, Westwood Building, National Institutes of Health, Bethesda, MD 20892. Telephone: (301) 496-7966.

Date of meeting: June 20, 1986.

Place of meeting: Linden Hill Hotel, Conference Room 22, 5400 Pooks Hill Road, Bethesda, MD 20814.

Open: June 20, 8:30 a.m.—9:10 a.m. and 2:30 p.m.—adjournment.

Agenda

Reports from Director and Deputy Director, Immunology, Allergic, and Immunologic Diseases Program (IAIDP); and Director and Deputy Director, Extramural Activities Program on Committee concerns and IAIDP program presentation.

Closed: June 20, 9:10 a.m.—2:30 p.m.

Closure reason: To review grant applications and contract proposals.

Name of committee: Transplantation Biology and Immunology Subcommittee of the Allergy, Immunology, and Transplanation Research Committee.

Executive secretary: Dr. Nirmal Das, Room 706, Westwood Building, National Institutes of Health, Bethesda, MD 20892. Telephone: (301) 496-7966.

Date of meeting: June 27, 1986.

Place of meeting: Building 31A, Conference Room 4, National Institutes of Health, 9000 Rockville Pike, Bethesda, MD 20892.

Open: June 27, 8:30 a.m.—9:10 a.m. and 1:40 p.m.—adjournment.

Agenda

Reports from Director and Deputy Director, Immunology, Allergic, and Immunologic Diseases Program (IAIDP); and Director and Deputy Director, Extramural Activities Program on Committee concerns followed by Program concept clearances and IAIDP.

Closed: June 27, 9:10 a.m.—1:40 p.m.

Closure reason: To review grant applications and contract proposals.

(Catalog of Federal Domestic Assistance Programs Nos. 13.855, Pharmacological Sciences; 13.856, Microbiology and Infectious Diseases Research, National Institutes of Health)

Dated: May 22, 1986.

Betty J. Beveridge,

Committee Management Officer, NIH.

[FR Doc. 86-12411 Filed 6-2-86; 8:45 am]

BILLING CODE 4140-01-M

Social Security Administration

Privacy Act of 1974; Notification of New System of Records

AGENCY: Social Security Administration (SSA), Department of Health and Human Services (HHS).

ACTION: New system of records.

SUMMARY: In accordance with the Privacy Act (5 U.S.C. 552a(e)(4)), we are issuing public notice of our intent to establish a new system of records. The proposed system of records is entitled "Kentucky Birth Records System, HHS/SSA/DO(KY), 09-60-0220." Information in the proposed system of records will be used by Social Security offices in the State of Kentucky to establish proof or age and other facts, as necessary, in processing applications for various Social Security benefits, Supplemental Security Income payments and Social Security numbers (SSN's). We are proposing routine use disclosures of information which will be maintained in the proposed system of records as discussed below. We invite public comments on this proposal.

DATES: We filed a report of a new system of records with the President of the Senate, the Speaker of the House of Representatives and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget, on May 23, 1986. The proposed system will become effective as proposed without further notice on July 22, 1986, unless we receive comments on or before that date which would result in a contrary determination.

FOR FURTHER INFORMATION CONTACT: Mr. Bert Sisk, District Manager, Social Security Administration, 330 Broadway, P.O. Box 579, Frankfort, Kentucky 40601, telephone (Area Code 502) 875-2231.

SUPPLEMENTARY INFORMATION:

I. Purpose, Background, and Contents of the Proposed System of Records

Individuals applying for entitlement under various Social Security programs must furnish SSA with evidentiary proof of age when age is a factor of entitlement. Additionally, evidence of age must be furnished when an individual applies for an SSN. Preferred proof of age is a public birth record or religious record of birth which was recorded before the age of 5. However, other documentation such as a school record also may be acceptable as evidentiary proof of age for entitlement purposes or for issuance of an SSN.

Generally, claimants have the responsibility for furnishing the proofs that are necessary to support their claims. However, we will assist claimants who are unable to obtain necessary documentation through their own efforts. In this regard, the State of Kentucky has prepared an index of birth records registered in that State and has offered to furnish the index to SSA. Kentucky will certify the accuracy of information on the index prior to furnishing it to SSA. We plan to obtain the index for use by Social Security offices in Kentucky whenever SSA must establish the age of individuals to determine entitlement under its programs or to issue an SSN. Further, other information contained in the index of birth records could be useful in determining other facts which could bear on entitlement; e.g., a parent's name could be used to establish relationship. Use of the index of birth records would obviate SSA or the individual otherwise obtaining a copy of a birth record from the State. This would help reduce the processing time of applications for entitlement under SSA programs or for obtaining SSN's.

The Kentucky Office of Vital Statistics will compile information on the index of birth records directly from birth records registered in that State. Specific information on the index will consist of the individual's name, date and place of birth, mother's maiden name, birth certificate number and the volume number of the index. We will retrieve information by use of the individual's name and other identifying information. Our use of the index, thus, would constitute a system of records as defined by the Privacy Act (5 U.S.C. 552a(a)(5)).

II. Proposed Routine Use Disclosures of Information Maintained in the Proposed System of Records

We are proposing to establish routine use disclosures of information which will be maintained in the proposed system of records as discussed below.

A. Disclosure to a congressional office in response to an inquiry from that office made at the request of the subject of a record.

This proposed routine use would enable SSA to disclose information to a congressional representative in those instances in which the subject of a record may ask the representative to intercede in a matter on his/her behalf involving this system of records and SSA. Information would be disclosed only when the representative makes an inquiry and presents evidence that he/she is acting on behalf of the individual whose record is requested.

b. Disclosure to the Department of Justice (DOJ), to a court or other tribunal, or another party before such tribunal, when:

(1) *HHS/SSA, or any component thereof; or*

(2) *Any HHS/SSA employee in his/her official capacity; or*

(3) *Any HHS/SSA employee in his/her individual capacity where DOJ (or HHS/SSA where it is authorized to do so) has agreed to represent the employee; or*

(4) *The United States or any agency thereof where HHS/SSA determines that the litigation is likely to affect the operations of HHS/SSA or any of its components,*

is a party to litigation or has an interest in such litigation, and HHS/SSA determines that the use of such records by DOJ, the tribunal, or the other party before such tribunal is relevant and necessary to the litigation, provided, however, that in each case, HHS/SSA determines that such disclosure is compatible with the purpose for which the records were collected.

Disclosure would be made under this proposal, as necessary, to defend HHS/SSA components or employees in litigation matters involving this system or when HHS/SSA has an interest in litigation which might affect HHS/SSA operations.

III. Compatibility of Proposed Routine Uses

The Privacy Act (5 U.S.C. 552a(b)(3)) and our disclosure regulation permit us to disclose information as a routine use for purposes which are compatible with the purpose for which we collect information. The regulation (20 CFR 401.310) permits us to disclose information as a routine use to administer our programs or similar income-maintenance or health-maintenance programs of other agencies. Disclosure would be made

under the proposed routine uses to provide a service to Social Security constituents and, as necessary, in litigation matters involving HHS/SSA operations and the proposed system. We consider disclosure in both instances as extensions of our program administration. Thus, the routine uses are appropriate and meet the criteria in the regulation.

IV. Safeguards Applicable to the Proposed System of Records

We will restrict access to records maintained in the proposed system to SSA employees who need the records in the performance of their official duties. The record will be maintained in secured facilities and, when not in use, will be kept from access by unauthorized individuals (e.g., stored in locked filing cabinets).

V. Effect of the Proposed System of Records on Individual Rights

Information in the proposed system of records will be used only to establish required proof of age and other facts about individuals applying for various benefits or payments administered by SSA or for SSN's. However, any individual who disputes the accuracy of information or objects to SSA's use of the records will be given an opportunity to present alternative supporting evidence on his/her behalf such as a certified copy of his/her birth certificate. Further, once the system is implemented, any individual who believed that he/she had been adversely affected by a decision which was based on information in the system would have the right to appeal the decision. Thus, we do not believe that use of the proposed system would result in any unwarranted adverse effects on individual rights.

Dated: May 23, 1986.

Martha A. McSteen,

Acting Commissioner of Social Security.

09-60-0220

System name:

Kentucky Birth Records System, HHS/SSA/DO(KY).

Security classification:

None.

System location:

Social Security district and branch offices located in the State of Kentucky. Individuals should consult Kentucky telephone directories for address and telephone information.

Categories of individuals covered by the system:

Members of the general public whose birth records have been registered in the State of Kentucky.

Categories of records in the system:

The system consists of an index of Kentucky birth records. Included on the index are the individual's name, mother's maiden name, date and place of birth, birth certificate number and volume number of the index.

Purpose:

Information in the system will be used by Social Security Administration (SSA) offices in the State of Kentucky to provide evidentiary proof of age and other facts about individuals applying for various Social Security benefits, Supplemental Security Income payments and Social Security numbers.

Routine uses of records maintained in the system, including categories of users and the purposes of such uses:

Disclosure may be made as routine uses as indicated below:

1. To a Congressional office in response to an inquiry from that office made at the request of the subject of a record.

2. To the Department of Justice (DOJ), to a court or other tribunal, or to another party before such tribunal, when:

(a) The Department of Health and Human Services (HHS)/SSA, or any component thereof; or

(b) Any HHS/SSA employee in his/her official capacity; or

(c) Any HHS/SSA employee in his/her individual capacity where DOJ (or HHS/SSA where it is authorized to do so) has agreed to represent the employee; or

(d) The United States or any agency thereof where HHS/SSA determines that the litigation is likely to affect the operations of HHS/SSA or any of its components,

Is a party to litigation or has an interest in such litigation, and HHS/SSA determines that the use of such records by DOJ, the tribunal, or the other party before such tribunal is relevant and necessary to the litigation, provided, however, that in each case, HHS/SSA determines that such disclosure is compatible with the purpose for which the records were collected.

Policies and practices for storing, retrieving, accessing, retaining and disposing of records in the system:

Storage:

Records will be stored on microfilm.

Retrievability:

Records will be retrieved by the individuals's name and other identifying information (e.g., mother's name and date of birth).

Safeguards:

Access to records in the system will be restricted to personnel who need them in the performance of their official duties. Also, the information will be maintained in secured facilities and kept from access by unauthorized individuals (e.g., stored in locked filing cabinets) when not in use.

Retention and disposal;

Records in the system will be updated biennially. Out-of-date microfilm records will be disposed of by the application of heat.

System manager(s) and address:

Managers of Social Security district/branch offices in the State of Kentucky. Individuals seeking office addresses and telephone numbers should consult Kentucky telephone directories.

Notification procedures:

An individual wishing to find out if this system of records contains information about him/her may do so by contacting any Social Security office and furnishing his/her name, date and place of birth and mother's maiden name. These procedures are in accordance with HHS Regulations 45 CFR Part 5b.

Record access procedures:

Same as notification procedures above. Also, individuals requesting access to their records should reasonable describe the records they are seeking. These procedures are in accordance with HHS Regulations 45 CFR Part 5b.

Contesting record procedures:

Same as notification procedures above. Also, individuals contesting the contents of records in the systems should reasonably describe the records, specify the information they are contesting and state the corrective action sought with supporting justification showing how the records are untimely, incomplete, inaccurate or irrelevant. These procedures are in accordance with HHS Regulations 45 CFR Part 5b.

Record source categories:

Records in the system will be obtained from the Kentucky Office of Vital Statistics.

System exempted from certain provisions of the act:

None.

[FR Doc. 86-12396 Filed 6-2-86; 8:45 am]

BILLING CODE 4190-11-M

DEPARTMENT OF THE INTERIOR

Senior Executive Service; Performance Review Board Appointments.

May 12, 1986.

AGENCY: Department of the Interior.

ACTION: Notice of Performance Review Board appointments.

SUMMARY: This notice provides the names of individuals who have been appointed to serve as members of the Department of the Interior Performance Review Boards. The publication of these appointments is required by section 405(a) of the Civil Service Reform Act of 1978 (Pub. L. 95-454, 5 U.S.C. 4314(c))(4)).

DATE: These appointments are effective upon publication in the **Federal Register.**

FOR FURTHER INFORMATION CONTACT: Morris A. Simms, Director of Personnel, Office of the Secretary, Department of the Interior, 1800 C Street, NW., Washington, DC 20240, Telephone Number: 343-6761.

Departmental PRB

Ann D. McLaughlin, Chairperson
James Biesecker (Career)
Robert Lawton (Career)
Michael O'Bannon (Career)
J. Lisle Reed (Career)
Hazel Elbert (Career)

Office of the Secretary PRB

Joseph Gorrell (Career), Chairperson
Charlotte Spann (Career)
Martin Smith (Noncareer)
Oscar Mueller (Career)
William Kendig (Career)

Assistant Secretary—Indian Affairs PRB

Earl Barlow (Career, Field), Chairperson
William Babby (Career, Field)
Richard Whitesell (Career, Field)
Frank Ryan (Career)

Office of the Solicitor PRB

Gale A. Norton (Noncareer), Chairman
Christopher Cannon (Noncareer)
W. Pierce Elliott (Career)
David Watts (Career, Field)
Ruth VanCleve (Career)

Assistant Secretary for Fish and Wildlife and Parks PRB

P. Daniel Smith (Noncareer), Chairperson
Jerry Rogers (Career)
Robert Gilmore (Career, Field)
John Cook (Career, Field)
Edward Davis (Career)

Assistant Secretary—Water and Science PRB

William Klostermeyer (Career), Chairperson
Clifford Barrett (Career)
James E. Cook (Career)
Richard Witmer (Career)
Robert Hamilton (Career)
Lewis Wade (Career, Field)

Assistant Secretary—Land and Minerals Management PRB

James Cason (Noncareer), Chairperson
Thomas Gernhofer (Career)
Robert Boldt (Career)
George Brown (Career)
Neil Morck (Career, Field)

Dated: May 12, 1986.

Gerald R. Riso,

Assistant Secretary for Policy, Budget, and Administration.

[FR Doc. 86-12363 Filed 6-2-86; 8:45 am]

BILLING CODE 4310-10-M

Bureau of Indian Affairs

Establishment of Reservation; Jamestown Klallam Tribe

May 7, 1986.

This notice is published in the exercise of authority delegated by the Secretary of the Interior to the Assistant Secretary—Indian Affairs by 209 DM 8.1. Notice is hereby given that under the authority of section 7 of the Act of June 18, 1934 (25 U.S.C. 467; 48 Stat. 986), the hereinafter described land located in Clallam County, Washington, was proclaimed to be an Indian reservation effective May 7, 1986, for exclusive use of Indians entitled by enrollment or by tribal membership to residence at such reservation.

Willamette Meridian

Clallam County, Washington

Tract 5 of Lot 1 of Assessor's Map of section 12, Township 29 North, Range 3 West, as recorded in Volume 4 of Plats, Page 5, records of Clallam County, Washington, and

Except a right-of-way conveyed to Seattle, Port Angeles and Lake Crescent Railway by deed recorded in Volume 94 of Deeds, page 107, records of Clallam County, Washington, and

Except Primary State Highway No. 9, and

Except any portion lying southerly of the following described line: Beginning at the meander corner between sections 1 and 12, Township 29 North, Range 3 West; thence north 89°20'11" east 628.46 feet to the northeast corner of said section 12; thence south 17°58'30" west 1367.00 feet to a point on the west margin of the Old Olympic Highway, said point being one-half inch steel rod in concrete, and the true point of beginning; thence south 88°23'15" west to the mean high tide line, and the end of the described line; containing 2.12 acres, more or less, after the above exceptions, together with tidelands of the second class situate in front of, adjacent to or abutting upon the south 295 feet of Lot 1 of section 12, as set forth in deed on file here in the Bureau of Indian Affairs, Portland Area Title Plant number 130-1891.

Said land being subject to all valid rights, reservations, rights-of-way and easements of record.

Ross O. Swimmer,

Assistant Secretary—Indian Affairs.

[FR Doc. 86-12385 Filed 6-2-86; 8:45 am]

BILLING CODE 4310-02-M

Bureau of Land Management

[M 40644, et al.]

Proposed Continuation of Withdrawals; Montana

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Reclamation, Department of the Interior, proposes to continue all or part of 6 existing land withdrawals for the Milk River Project for 50 years. The 24,581.18 acres of withdrawn unpatented lands proposed for continuation would remain closed to surface entry and mining. The extraction of locatable minerals from these lands would be permitted by the Bureau of Reclamation, provided this extraction can be performed in a manner that would not jeopardize or otherwise interfere with the purposes of the Milk River Project. All of the lands have been and would continue to be open to the mineral leasing laws.

FOR FURTHER INFORMATION CONTACT: James Binando, Chief, Branch of Land Resources, BLM, Montana State Office, P.O. Box 36800, Billings, Montana 59107, Phone (406) 657-6090.

The Bureau of Reclamation proposes that the existing land withdrawals made by Secretarial Orders of October 8, 1904, May 12, 1945, October 15, 1904, October 23, 1944, June 15, 1937, and September 8, 1903, be continued in their entirety or in part for 50 years pursuant to section 204 of the Federal Land Policy and Management Act of 1976, 90 Stat. 2751, 43 U.S.C. 1714.

The purpose for continuance of the withdrawals is to protect the Milk River Reclamation Project. The withdrawals would continue to segregate 24,581.18 acres of unpatented lands located in

Blaine, Hill, and Phillips Counties in the State of Montana from operation of the public land laws and location under the United States mining laws; however, the extraction of locatable minerals would be permitted by the Bureau of Reclamation, provided that this extraction could be performed in a manner that would not jeopardize or otherwise interfere with the purposes of the Milk River Project. All of the lands would continue to be open to mineral leasing.

No change is proposed in the purpose or segregative effect of the withdrawals.

For a period of 90 days from the date of publication of the notice, all persons who wish to submit comments, suggestions, or objections in connection with the proposed withdrawal continuations may present their views in writing to the undersigned office at the address specified above.

The authorized officer of the Bureau of Land Management will undertake such investigations as are necessary to determine the existing and potential demand for the lands and its resources. A report will also be prepared for consideration by the Secretary of the Interior, the President, and Congress who will determine whether or not the withdrawals will be continued and, if so, for how long. The final determination on the continuation of the withdrawal will be published in the **Federal Register**. The existing withdrawals will continue until such final determination is made.

Dated: May 27, 1986.

James Binando,

Chief, Branch of Land Resources.

[FR Doc. 86-12359 Filed 6-2-86; 8:45 am]

BILLING CODE 4310-DN-M

Minerals Management Service

Development Operations Coordination Document

AGENCY: Minerals Management Service.

ACTION: Notice of the Receipt of a Proposed Development Operations Coordination Document (DOCD).

SUMMARY: Notice is hereby given that Amoco Production Company has submitted a DOCD describing the activities it proposes to conduct on Lease OCS-G 6032, Block 519, Matagorda Island Area, offshore Texas. Proposed plans for the above area provide for the development and production of hydrocarbons with support activities to be conducted from an onshore base located at Port O'Connor, Texas.

DATE: The subject DOCD was deemed submitted on May 27, 1986.

ADDRESS: A copy of the subject DOCD is available for public review at the Office of the Regional Director, Gulf of Mexico OCS Region, Minerals Management Service, 3301 North Causeway Blvd., Room 147, Metairie, Louisiana (Office Hours: 9 a.m. to 3:30 p.m., Monday through Friday).

FOR FURTHER INFORMATION CONTACT: Michael J. Tolbert; Minerals Management Service; Gulf of Mexico OCS Region; Rules and Production; Plans, Platform and Pipeline Section; Exploration/Development Plans Unit; Phone (504) 838-0875.

SUPPLEMENTARY INFORMATION: The purpose of this Notice is to inform the public, pursuant to sec. 25 of the OCS Lands Act Amendments of 1978, that the Minerals Management Service is considering approval of the DOCD and that it is available for public review.

Revised rules governing practices and procedures under which the Minerals Management Service makes information contained in DOCDs available to affected States, executives of affected States, local governments, and other interested parties became effective December 13, 1979, (44 FR 53685). Those practices and procedures are set out in revised § 250.34 of Title 30 of the CFR.

Dated: May 27, 1986.

J. Rogers Pearcy,

Regional Director, Gulf of Mexico OSC Region.

[FR Doc. 86-12356 Filed 6-2-86; 8:45 am]

BILLING CODE 4310-MR-M

National Park Service

National Register of Historic Places; Notification of Pending Nominations

Nominations for the following properties being considered for listing in the National Register were received by the National Park Service before May 24, 1986. Pursuant to section 60.13 of 36 CFR Part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded to the National Register, National Park Service, U.S. Department of the Interior, Washington, DC 20243. Written comments should be submitted by June 18, 1986.

Carol D. Shull,

Chief of Registration, National Register.

ARIZONA

Pima County

Tucson, *Iron Horse Expansion Historic District,* Roughly bounded by Eighth St., Euclid Ave., Hughes & 10th Sts., and N. Fourth & Hoff Aves.

COLORADO

Denver County

Denver, *San Rafael Historic District,* Roughly bounded by Washington, E. 26th Ave., Downing, and E., 20th Ave.

El Paso County

Colorado Springs, *Cutler Hall (Colorado College TR),* 912 N. Cascade Ave.
Colorado Springs, *Palmer Hall (Colorado College TR),* 116 E. San Rafael St.

Garfield County

Glenwood Springs, *Starr Manor,* 901 Palmer Ave.

Phillips County

Haxtun, *First National Bank of Haxtun,* 145 S. Colorado Ave.

GEORGIA

Walker County

Rossville, *Rossville Post Office,* 301 Chickamauga Ave.

ILLINOIS

Franklin County

Mulkeytown vicinity, *Silkwood Inn (Shawneetown—Kaskaskia—St. Louis Trail TR),* N of Mulkeytown off IL 14.
Mulkeytown vicinity, *Trace at Hall—Treadwell—Miller Site (Shawneetown—Kaskaskia—St. Louis Trail, TR)* NW of Mulkeytown.
Mulkeytown vicinity, *Trail Segment North of Silkwood Inn (Shawneetown—Kaskaskia—St. Louis Trail TR)* N of Mulkeytown off IL 14.
Mulkeytown, *Reid—Kirkpatrick Cemetery (Shawneetown—Kaskaskia—St. Louis TR),* E side of Little Muddy River.
Plumfield, *Plumfield Bridge (Shawneetown—Kaskaskia—St. Louis Trail TR),* IL 149.
Plumfield, *Plumfield Ford (Shawneetown—Kaskaskia—St. Louis Trail TR),* Big Muddy River off IL 149, near Gauging Station.
Plumfield, *Trace at Plumfield (Shawneetown—Kaskaskia—St. Louis Trail TR),* E bank of Big Muddy off IL 149.

INDIANA

Hamilton County

Carmel vicinity, *Newby, Micah, House,* 1149 W. 116th St.

Marion County

Indianapolis, *Julian—Clarke Residence,* 115 S. Audubon Rd.

MINNESOTA

Chippewa County

Granite Falls, *Weaver, Julian A., House,* 837 Minnesota Ave.

Fillmore County

Rushford, *Southern Minnesota Depot,* Elm St. and Pickle Alley.

Hennepin County

Minneapolis, *First Church of Christ Scientist,* 614-620 E. Fifteenth St.

Lac qui Parle County

Louisburg, *District School No. 92,* First St. at Third Ave.

Norman County

Canning Site.

Yellow Medicine

Canby, *Lundring Service Station,* 201 First St. E.

New York

Columbia County

Hudson, *Front Street-Parade Hill-Lower Warren Street Historic District (Boundary Decrease),* Warren St. roughly bounded by N & S Second, Cherry Alley, N side of Front St., and Penn Central RR.

Monroe County

Rochester, *Central Downtown YMCA Building (Inner Loop MRA),* 100 Gibbs St.

[FR Doc. 86-12306 Filed 6-2-86; 8:45 am]
BILLING CODE 4310-70-M

DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

[Application No. D-6263 et al.]

Proposed Exemptions; Memphis Construction, Inc., et al.

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Notice of proposed exemptions.

SUMMARY: This document contains notices of pendency before the Department of Labor (the Department) of proposed exemptions from certain of the prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974 (the Act) and/or the Internal Revenue Code of 1954 (the Code).

Written Comments and Hearing Requests

All interested persons are invited to submit written comments or requests for a hearing on the pending exemptions, unless otherwise stated in the Notice of Pendency, within 45 days from the date of publication of this **Federal Register** Notice. Comments and requests for a hearing should state the reasons for the writer's interest in the pending exemption.

ADDRESS: All written comments and requests for a hearing (at least three copies) should be sent to the Pension and Welfare Benefits Administration, Office of Regulations and Interpretations, Room N-5669, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. Attention: Application No. stated in each Notice of Pendency, The applications for exemption and the comments received will be available for public inspection in the Public Documents Room of Pension and Welfare Benefit Programs, U.S. Department of Labor, Room N-4677, 200 Constitution Avenue, NW., Washington, DC 20210.

Notice to Interested Persons

Notice of the proposed exemptions will be provided to all interested persons in the manner agreed upon by the applicant and the Department within 15 days of the date of publication in the **Federal Register.** Such notice shall include a copy of the notice of pendency of the exemption as published in the **Federal Register** and shall inform interested persons of their right to comment and to request a hearing (where appropriate).

SUPPLEMENTARY INFORMATION: The proposed exemptions were requested in applications filed pursuant to section 408(a) of the Act and/or section 4975(c)(2) of the Code, and in accordance with procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). Effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to issue exemptions of the type requested to the Secretary of Labor. Therefore, these notices of pendency are issued solely by the Department.

The applications contain representations with regard to the proposed exemptions which are summarized below. Interested persons are referred to the applications on file with the Department for a complete statement of the facts and representations.

Employees' Profit Sharing and Retirement Plan of Memphis Construction, Inc. (the Plan) Located in Memphis, New York

[Application No. D-6263]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed sale of certain real property by the Plan to Memphis Construction, Inc. (the Plan Sponsor) provided all of the terms of the proposed transaction are as favorable to the Plan as those obtainable in an arm's-length transaction with an unrelated party on the date of the consummation of the transaction.

Summary of Facts and Representations

1. The Plan is a defined contribution profit sharing plan with approximately 95 participants. The Plan had total assets of $694,441 as of November 30, 1984. The trustee of the Plan is Mr. Duane C. Olin (the Trustee). The Trustee is an officer and shareholder of the Plan Sponsor. The Plan Sponsor is a real estate development corporation.

2. The Plan is the owner of a parcel of vacant land including approximately 46 acres in the Town of Clay, Onondaga County, New York (the Property) [1] which was purchased from unrelated parties. At the time of its purchase, the Trustee decided that the purchase of this real property would diversify the Plan's investment portfolio and could be held for appreciation. The Trustee determined that the purchase price of the real property was reasonable in view of its growth potential, and that its purchase would be a suitable investment for the Plan.

3. The applicant represents that the purchase of the real property was not motivated by any intention to benefit a particular Plan participant, group of participants, nor the Plan Sponsor. In a sworn affidavit, the Trustee represented that on June 4, 1982, he authorized the purchase of the real property and that prior to its purchase, the fair market value was established by an independent real estate appraiser at $285,000 as of April 22, 1982. (According to the above-mentioned appraisal, the total purchase price of $184,978 represented approximately 65% of its fair market value.)

4. The applicant proposes that the Plan Sponsor purchase the Property from the Plan. The Plan Sponsor submitted an offer to purchase the Property dated May 23, 1985. The total purchase price will be $210,208. The Plan Sponsor will pay all charges in connection with the sale. An independent appraisal of the Property was performed by G. Richard Kelley, M.A.I., C.R.E., of Pomeroy Appraisal

[1] Originally the Plan purchased 49 acres of real property at a cost of $173,069 plus closing expenses of $11,009 for a total of $184,078. The Plan subsequently sold a parcel to an unrelated party for $50,000. The applicant represents that this sales price reflected a 230% gain above the amount the Plan invested in this 3-acre parcel.

Associates, Inc., located in Syracuse, New York (the Appraisal). The Appraisal established the fair market value of the Property at $210,000 as of April 22, 1985. Total costs to the Plan of the Property, including carrying expenses, amounted to $114,000.

5. Mr. Thomas J. Bader, CEBS, of Retirement Income Services, Inc. located in Syracuse, New York, has made an independent review of the proposed transaction. Mr. Bader is unrelated to the Plan or the Plan Sponsor. Mr. Bader noted that it is customary for most pension funds to limit the exposure real estate investments to between 10 to 20 of total plan assets. However, the Plan has over 57 percent of the total portfolio invested in real estate as of November 30, 1984. Mr. Bader believes that the extremely large percentage of the Plan's assets invested in non-income producing properties is justification for the sale of the Property and such sale would be in the best interests of the Plan and its participants and beneficiaries. In summary, Mr. Bader represents that the Plan would be much more diversified in income producing securities which could easily be sold if need be, rather than in an illiquid, non-income producing asset such as the Property; the rate of appreciation that the Property has achieved is good and the future returns that may be achieved are questionable. He therefore recommends the sale of the Property and respresents that such sale would be in the best interests of the Plan and its participants and beneficiaries.

6. In summary, the applicant represents that the proposed transaction meets the statutory criteria of section 408(a) of the Act because:

(a) The sale of the Property will yield a significant gain over the investment.

(b) The Plan will not incur any expenses with respect to the sale of the Property. Therefore, the proceeds received by the Plan would be greater than those obtainable from an independent third party purchaser due to the absence of sales brokerage commissions and other costs which the Plan would pay in a standard commercial sales transaction.

(c) The sale of the Property will make possible greater diversification in the investments of the Plan.

(d) The Plan will receive fair market value for the Property as determined by an independent appraiser.

(e) An independent party has reviewed the proposed transaction and determined that the sale of the Property is in the best interests of and protective of the Plan; and

(f) The Trustee has determined that the proposed transaction is in the interests of and protective of the Plan.

For Further Information Contact: Ms. Linda Hamilton of the Department, telephone (202) 523-8194. (This is not a toll-free number.)

Circleville Publishing Company Profit Sharing Plan (the Plan) Located in Circleville, Ohio

[Application No. D-6517]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed sale to Circleville Publishing Company (the Employer), a party in interest with respect to the Plan, of the shares of Press Properties, Inc. (Press) owned by the Plan, provided the sales price is not less than the fair market value of such shares on the date of the sale.

Summary of Facts and Representations

1. The Plan is a profit-sharing plan covering 24 participants as of December 31, 1984. The fair market value of the Plan's total assets was $946,936.00 as of March 7, 1986. The current trustee of the Plan is The Huntington National Bank, of Columbus Ohio (the Trustee), which requested the application for exemption as a condition of continuing to act as trustee of the Plan. The Trustee represents that it has no relationship with the Employer, its principals, or affiliates.

2. Press is a closely held corporation owned by 16 shareholders, including the Plan, five profit-sharing plans maintained by other employers, five companies, and five individuals. The largest shareholder of Press owns 16.0% of its 6,309 outstanding shares. As of June 30, 1985, six parcels of improved real property, all located in small farm communities in Ohio (Circleville, Van Wert, Logan, Wilmington, Hillsboro, and Washington Court House), comprised over 70% of Press' assets, the remainder of which consisted of cash and other liquid assets. Each of these six parcels is used for newspaper production, under a leasing or subleasing arrangement, by a different newspaper publishing company, namely: The Employer, Washington News Publishing Company, Van Wert Publishing Company, Wayne Newspaper Company, News-Journal Company, and Hillsboro Publishing Company (collectively, the Tenants). All of the Tenants maintain profit-sharing plans which own shares of Press. All such shares were purchased by such plans at various dates from 1969 through 1972 (before enactment of the Act). After obtaining appraisals by Mr. Tom Wilhelm, M.A.I., of each parcel of real property owned by Press, the Trustee determined that the fair market value of the outstanding shares of Press was $146.87 per share as of June 30, 1985. Mr. Wilhelm represents that he has no relationship with Press, any of the Tenants, or their affiliates or principals.

3. The applicant represents that Press is not an affiliate, for purposes of section 407(d)(7) of the Act, of any of the Tenants. All Tenants except Hillsboro Publishing Company may comprise various controlled groups, but, according to the applicant, until the current audit is completed the extent of the controlled groups cannot be determined.

4. The Plan owns a total of 918 shares of Press, representing approximately 14.5% of the Plan's total assets. The Plan paid $91,800 for these shares ($100 per share). The Trustee wishes to sell these shares to the Employer at a price equal to the fair market value of the shares on the date of the sale. The entire price will be paid in cash on the date of the sale. The Plan will pay no commissions or other expenses relating to the proposed sale.

5. The Trustee states that when the Plan purchased the 918 shares, companies with substantial real-estate holdings were thought to be prudent investments and that, in general, real estate was an excellent investment from 1970 through 1985. Therefore, the Trustee speculates that the previous trustee of the Plan acquired and held these shares for the Plan in the belief that companies with real-estate holdings were prudent investments.[2]

6. When the Trustee became trustee of the Plan, it was concerned about the concentration of Press shares owned by the Plan, particularly in light of the poor economic forecast for smaller towns dependent upon the depressed agricultural sector of the economy. In addition, the Trustee did not want the administrative burden and expense of appraising closely held companies and would prefer to diversify the

[2] The Department is expressing no opinion herein as to whether or not the continued holding by the Plan (or any of the other plans mentioned in 2, above) of shares of Press constituted either a prohibited transaction under section 406 of the Act or a violation of any of the other fiduciary responsibility provisions of Part 4, Subtitle B, of Title I of the Act.

investments of the Plan. The Trustee states that there is virtually no market for the Press shares and that other Press shareholders have been notified and have no interest in purchasing additional shares of Press. The Trustee asserts that unless the Employer purchases the Press shares owned by the Plan, the Plan's assets could depreciate in value as no upturn in the real-estate market is anticipated. The proposed sales price will equal the fair market value of the Press shares on the date of the proposed sale, according to the Trustee. For these reasons, the Trustee believes it to be in the best interests of the Plan and its participants and beneficiaries to sell its holdings of Press shares and to reinvest the proceeds in other types of more liquid investments.

7. In summary, the applicant represents that the proposed transaction satisfies the exemption criteria set forth in section 408(a) of the Act because: (a) The proposed transaction is a one-time cash transaction; (b) the proposed sales price will equal the fair market value of the shares on the date of the sale as determined by the Trustee; (c) the Plan will pay no commissions or other expenses relating to the proposed sale; and (d) the Trustee, who is not related to the Employer, its principals or affiliates, believes the proposed sale will spare the Plan from risk of loss and will permit the Plan to diversify further by investing in more liquid assets.

For Further Information Contact: Mrs. Miriam Freund of the Department, telephone (202) 523-8194. (This is not a toll-free number.)

The Washington News Publishing Company Profit Sharing Plan (the Plan) Located in Washington Court House, Ohio

[Application No. D-6520]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed sale to The Washington News Publishing Company (the Employer), a party in interest with respect to the Plan, of the shares of Press Properties, Inc. (Press) owned by the Plan, provided the sales price is not less than the fair market value of such shares on the date of the sale.

Summary of Facts and Representations

1. The Plan is a profit-sharing plan covering 23 participants as of December 31, 1984. The fair market value of the Plan's total assets was $636,821 as of December 30, 1985. The current trustee of the Plan is The Huntington National Bank, of Columbus Ohio (the Trustee), which requested the application for exemption as a condition of continuing to act as trustee of the Plan. The Trustee represents that it has no relationship with the Employer, its principals, or affiliates.

2. Press is a closely held corporation owned by 16 shareholders, including the Plan, five profit-sharing plans maintained by other employers, five companies, and five individuals. The largest shareholder of Press owns 16.0% of its 6,309 outstanding shares. As of June 30, 1985, six parcels of improved real property, all located in small farm communities in Ohio (Circleville, Van Wert, Logan, Wilmington, Hillsobor, and Washington Court House), comprised over 70% of Press' assets, the remainder of which consisted of cash and other liquid assets. Each of these six parcels is used for newspaper production, under a leasing or subleasing arrangement, by a different newspaper publishing company, namely: the Employer, Circleville Publishing Company, Van Wert Publishing Company, Wayne Newspaper Company, News-Journal Company, and Hillsboro Publishing Company (collectively, the Tenants). All of the Tenants maintain profit-sharing plans which own shares of Press. All such shares were purchased by such plans at various dates from 1969 through 1972 (before enactment of the Act). After obtaining appraisals by Mr. Tom Wilhelm, M.A.I., of each parcel of real property owned by Press, the Trustee determined that the fair market value of the outstanding shares of Press was $146.87 per share as of June 30, 1985. Mr. Wilhelm represents that he has no relationship with Press, any of the Tenants, or their affiliates or principals.

3. The applicant represents that Press is not an affiliate, for purposes of section 407(d)(7) of the Act, of any of the Tenants. All Tenants except Hillsboro Publishing Company may comprise various controlled groups, but, according to the applicant, until the current audit is completed the extent of the controlled groups cannot be determined.

4. The Plan owns a total of 1,009 shares of Press, representing approximately 23.4% of the Plan's total assets. The Plan paid $100,900 for these shares ($100 per share). The Trustee wishes to sell these shares to the Employer at a price equal to the fair market value of the shares on the date of the sale. The entire price will be paid in cash on the date of the sale. The Plan will pay no commissions or other expenses relating to the proposed sale.

5. The Trustee states that when the Plan purchased the 1,009 shares, companies with substantial real-estate holdings were thought to be prudent investments and that, in general, real estate was an excellent investment from 1970 through 1985. Therefore, the Trustee speculates that the previous trustee of the Plan acquired and held these shares for the Plan in the belief that companies with real-estate holdings were prudent investments.[3]

6. When the Trustee became trustee of the Plan, it was concerned about the concentration of Press shares owned by the Plan, particularly in light of the poor economic forecast for smaller towns dependent upon the depressed agricultural sector of the economy. In addition, the Trustee did not want the administrative burden and expense of appraising closely held companies and would prefer to diversify the investments of the Plan. The Trustee states that there is virtually no market for the Press shares and that other Press shareholders have been notified and have no interest in purchasing additional shares of Press. The Trustee asserts that unless the Employer purchases the Press shares owned by the Plan, the Plan's assets could depreciate in value as no upturn in the real-estate market is anticipated. The proposed sales price will equal the fair market value of the Press shares on the date of the proposed sale, according to the Trustee. For these reasons, the Trustee believes it to be in the best interests of the Plan and its participants and beneficiaries to sell its holdings of Press shares and to reinvest the proceeds in other types of more liquid investments.

7. In summary, the applicant represents that the proposed transaction satisfies the exemption criteria set forth in section 408(a) of the act because: (a) The proposed transaction is a one-time cash transaction; (b) the proposed sales price will equal the fair market value of the shares on the date of the sale as determined by the Trustee; (c) the Plan

[3] The Department is expressing no opinion herein as to whether or not the continued holding by the Plan (or any of the other plans mentioned in 2, above) of shares of Press constituted either a prohibited transaction under section 406 of the Act or a violation of any of the other fiduciary responsibility provisions of Part 4, Subtitle B, or Title I of the Act.

will pay no commissions or other expenses relating to the proposed sale; and (d) the Trustee, who is not related to the Employer, its principals or affiliates, believes the proposed sale will spare the Plan from risk of loss and will permit the Plan to diverisfy further by investing in more liquid assets.

For Further Information Contact: Mrs. Miriam Freund of the Department, telephone (202) 523-8194. (This is not a toll-free number.)

The Van Wert Publishing Company Profit Sharing Plan (the Plan) Located in Van West, Ohio

[Application No. D-6521]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 33, 1975). If the exemption is granted the restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed sale to The Van Wert Publishing Company (the Employer), a party in interest with respect to the Plan, of the shares of Press Properties, Inc. (Press) owned by the Plan, provided the sales price is not less than the fair market value of such shares on the date of the sale.

Summary of Facts and Representations

1. The Plan is a profit-sharing plan covering 22 participants as of December 31, 1984. The fair market value of the Plan's total assets was $581,826 as of December 30, 1985. The current trustee of the Plan is The Huntington National Bank of Columbus Ohio (the Trustee), which requested the application for exemption as a condition of continuing to act as trustee of the Plan. The Trustee represents that it has no relationship with the Employer, its principals, or affiliates.

2. Press is a closely held corporation owned by 16 shareholders, including the Plan, five profit-sharing plans maintained by other employers, five companies, and five individuals. The largest shareholder of Press owns 16.0% of its of 6,309 outstanding shares. As of June 30, 1985, six parcels of improved real property, all located in small farm communities in Ohio (Circleville, Van Wert, Logan, Wilmington, Hillsboro, and Washington Court House), comprised over 70% of Press' assets, the remainder of which consisted of cash and other liquid assets. Each of these six parcels is used for newspaper production, under a leasing or subleasing arrangement, by a different newspaper publishing company, namely: the Employer, Washington News Publishing Company, Circleville Publishing Company, Wayne Newspaper Company, News-Journal Company, and Hillsboro Publishing Company (collectively, the Tenants). All of the Tenants maintain profit-sharing plans which own shares of Press. All such shares were purchased by such plans at various dates from 1969 through 1972 (before enactment of the Act). After obtaining appraisals by Mr. Tom Wilhelm, M.A.I., of each parcel of real property owned by Press, the Trustee determined that the fair market value of the outstanding shares of Press was $146.87 per share as of June 30, 1985. Mr. Wilhelm represents that he has no relationship with Press, any of the Tenants, or their affiliates or principals.

3. The applicant represents that Press is not an affiliate, for purposes of section 407(d)(7) of the Act, of any of the Tenants. All Tenants except Hillsboro Publishing Company may comprise various controlled groups, but, according to the applicant, until the current audit is completed the extent of the controlled groups cannot be determined.

4. The Plan owns a total of 946 shares of Press, representing approximately 24% of the Plan's total assets. The Plan paid $94,600 for these shares ($100 per share). The Trustee wishes to sell these shares to the Employer at a price equal to the fair market value of the shares on the date of the sale. The entire price will be paid in cash on the date of the sale. The Plan will pay no commissions or other expenses relating to the proposed sale.

5. The Trustee states that when the Plan purchased the 946 shares, companies with substantial real-estate holdings were thought to be prudent investments and that, in general, real estate was an excellent investment from 1970 through 1985. Therefore, the Trustee speculates that the previous trustee of the Plan acquired and held these shares for the Plan in the belief that companies with real-estate holdings were prudent investments.[4]

6. When the Trustee became trustee of the Plan, it was concerned about the concentration of Press shares owned by the Plan, particularly in light of the poor economic forecast for smaller towns dependent upon the depressed agricultural sector of the economy. In addition, the Trustee did not want the administrative burden and expense of appraising closely held companies and would prefer to diversify the investments of the Plan. The Trustee states that there is virtually no market for the Press shares and that other Press shareholders have been notified and have no interest in purchasing additional shares of Press. The Trustee asserts that unless the Employer purchases the Press shares owned by the Plan, the Plan's assets could depreciate in value as no upturn in the real-estate market is anticipated. The proposed sales price will equal the fair market value of the Press shares on the date of the proposed sale, according to the Trustee. For these reasons, the Trustee believes it to be in the best interests of the Plan and its participants and beneficiaries to sell its holdings of Press shares and to reinvest the proceeds in other types of more liquid investments.

7. In summary, the applicant represents that the proposed transaction satisfies the exemption criteria set forth in section 408(a) of the Act because: (a) The proposed transaction is a one-time cash transaction; (b) the proposed sales price will equal the fair market value of the shares on the date of the sale as determined by the Trustee; (c) the Plan will pay no commissions or other expenses relating to the proposed sale; and (d) the Trustee, who is not related to the Employer, its principals or affiliates, believes the proposed sale will spare the Plan from risk of loss and will permit the Plan to diversify further by investing in more liquid assets.

For Further Information Contact: Mrs. Miriam Freund of the Department, telephone (202) 523-8194. (This is not a toll-free number.)

The Wayne Newspaper Company Profit Sharing Plan (the Plan) Located in Logan, Ohio

[Application No. D-6522]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a)

[4] The Department is expressing no opinion herein as to whether or not the continued holding by the Plan (or any of the other plans mentioned in 2, above) of shares of Press constituted either a prohibited transaction under section 406 of the Act or a violation of any of the other fiduciary responsibility provisions of Part 4, Subtitle B, or Title I of the Act.

and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed sale to The Wayne Newspaper Company (the Employer), a party in interest with respect to the Plan, of the shares of Press Properties, Inc. (Press) owned by the Plan, provided the sales price is not less than the fair market value of such shares of the date of the sale.

Summary of Facts and Representations

1. The Plan is a profit-sharing plan covering 22 participants as of December 31, 1984. The fair market value of the Plan's total assets was $412,428 as of December 30, 1985. The current trustee of the Plan is The Huntington National Bank, of Columbus Ohio (the Trustee), which requested the application for exemption as a condition of continuing to act as trustee of the Plan. The Trustee represents that it has no relationship with the Employer, its principals, or affiliates.

2. Press is a closely held corporation owned by 16 shareholders, including the Plan, five profit-sharing plans maintained by other employes, five companies, and five individuals. The largest shareholder of Press owns 16.0% of its 6,309 outstanding shares. As of June 30, 1985, six parcels of improved real property, all located in small farm communities in Ohio (Circleville, Van Wert, Logan, Wilmington, Hillsboro, and Washington Court House), comprised over 70% of Press' assets, the remainder of which consisted of cash and other liquid assets. Each of these six parcels is used for newspaper production, under a leasing or subleasing arrangement, by a different newspaper publishing company, namely: the Employer, Washington News Publishing Company Van Wert Publishing Company, Circleville Publishing Company, News-Journal Company, and Hillsboro Publishing Company (collectively, the Tenants). All of the Tenants maintain profit-sharing plans which own shares of Press. All such shares were purchased by such plans at various dates from 1969 through 1972 (before enactment of the Act). After obtaining appraisals by Mr. Tom Wilhelm, M.A.I., of each parcel of real property owned by Press, the Trustee determined that the fair market value of the outstanding shares of Press was $146.87 per share as of June 30, 1985. Mr. Wilhelm represents that he has no relationship with Press, any of the Tenants, or their affiliates or principals.

3. The applicant represents that Press is not an affiliate, for purposes of section 407(d)(7) of the Act, of any of the Tenants. All Tenants except Hillsboro Publishing Company may comprise various controlled groups, but, according to the applicant, until the current audit is completed the extent of the controlled groups cannot be determined.

4. The Plan owns a total of 501 shares of Press, representing approximately 18% of the Plan's total assets.The Plan paid $50,100 for these shares ($100 per share). The Trustee wishes to sell these shares to the Employer at a price equal to the fair market value of the shares on the date of the sale. The entire price will be paid in cash on the date of the sale. The Plan will pay no commissions or other expenses relating to the proposed sale.

5. The Trustee states that when the Plan purchased the 501 shares, companies with substantial real-estate holdings were thought to be prudent investments and that, in general, real estate was an excellent investment from 1970 through 1985. Therefore, the Trustee speculates that the previous trustee of the Plan acquired and held these shares for the Plan in the belief that companies with real-estate holdings were prudent investments.[5]

6. When the Trustee became trustee of the Plan, it was concerned about the concentration of Press shares owned by the Plan, particularly in light of the poor economic forecast for smaller towns dependent upon the depressed agricultural sector of the economy. In addition, the Trustee did not want the administrative burden and expense of appraising closely held companies and would prefer to diversify the investments of the Plan. The Trustee states that there is virtually no market for the Press shares and that other Press shareholders have been notified and have no interest in purchasing additional shares of Press. The Trustee asserts that unless the Employer purchases the Press shares owned by the Plan, the Plan's assets could depreciate in value as no upturn in the real-estate market is anticipated. The proposed sales price will equal the fair market value of the Press shares on the date of the proposed sale, according to the Trustee. For these reasons, the Trustee believes it to be in the best interests of the Plan and its participants and beneficiaries to sell its holdings of Press shares and to reinvest the proceeds in other types of more liquid investments.

7. In summary, the applicant represents that the proposed transaction satisfies the exemption criteria set forth in section 408(a) of the Act because: (a) The proposed transaction is a one-time cash transaction; (b) the proposed sales price will equal the fair market value of the shares on the date of the sale as determined by the Trustee; (c) the Plan will pay no commissions or other expenses relating to the proposed sale; and (d) the Trustee, who is not related to the Employer, its principals or affiliates, believes the proposed sale will spare the Plan from risk of loss and will permit the Plan to diversify further by investing in more liquid assets.

For Further Information Contact: Mrs. Miriam Freund of the Department, telephone (202) 523-8194. (This is not a toll-free number.)

The News-Journal Company Profit Sharing Plan (the Plan) Located in Wilmington, Ohio

[Application No. D-6523]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 408(a) of the Act and section 4975(c)(2) of the Code and in accordance with the procedures set forth in ERISA Procedure 75-1 (40 FR 18471, April 28, 1975). If the exemption is granted the restrictions of section 406(a) and 406 (b)(1) and (b)(2) of the Act and the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed sale to The News-Journal Company (the Employer), a party in interest with respect to the Plan, of the shares of Press Properties, Inc. (Press) owned by the Plan, provided the sales price is not less than the fair market value of such shares on the date of the sale.

Summary of Facts and Representations

1. The Plan is a profit-sharing plan covering 24 participants as of December 31, 1984. The fair market value of the Plan's total assets was $474,441 as of December 30, 1985. The current trustee of the Plan is The Huntington National Bank, of Columbus Ohio (the Trustee), which requested the application for exemption as a condition of continuing to act as trustee of the Plan. The Trustee represents that it has no relationship with the Employer, its principals, or affiliates.

2. Press is a closely held corporation owned by 16 shareholders, including the

[5] The Department is expressing no opinion herein as to whether or not the continued holding by the Plan (or any of the other plans mentioned in 2, above) of shares of Press constituted either a prohibited transaction under section 406 of the Act or a violation of any of the other fiduciary responsibility provisions of Part 4, Subtitle B, of Title I of the Act.

Plan, five profit-sharing plans maintained by other employers, five companies, and five individuals. The largest shareholder of Press own 16.0% of its 6,309 outstanding shares. As of June 30, 1985, six parcels of improved real property, all located in small farm communities in Ohio (Circleville, Van Wert, Logan, Wilmington, Hollsboro, and Washington Court House), comprised over 70% of Press' assets, the remainder of which consisted of cash and other liquid assets. Each of these six parcels is used for newspaper production, under a leasing or subleasing arrangement, by a different newspaper publishing company, namely: the Employer Washington News Publishing Company, Van Wert Publishing Company, Wayne Newspaper Company, Circleville Publishing Company, and Hillsboro Publishing Company (collectively, the Tenants). All of the Tenants maintain profit-sharing plans which own shares of Press. All such shares were purchased by such plans at various dates from 1969 through 1972 (before enactment of the Act). After obtaining appraisals by Mr. Tom Wilhelm, M.A.I., of each parcel of real property owned by Press, the Trustee determined that the fair market value of the outstanding shares of Press was $146.87 per share as of June 30, 1985. Mr. Wilhelm represents that he has no relationship with Press, any of the Tenants, or their affiliates or principals.

3. The applicant represents the Press is not an affiliate, for purposes of section 407(d)(7) of the Act, of any of the Tenants. All Tenants except Hillsboro Publishing Company may comprise various controlled groups, but according to the applicant, until the current audit is completed the extent of the Controlled groups cannot be determined.

4. The Plan owns a total of 896 shares of Press, representing approximately 27.8% of the Plan's total assets. The Plan paid $89,600 for these shares ($100 per share). The Trustee wishes to sell these shares to the Employer at a price equal to the fair market value of the shares on the date of the sale. The entire price will be paid in cash on the date of the sale. The Plan will pay no commissions or other expenses relating to the proposed sale.

5. The Trustee states that when the Plan purchased the 896 shares, companies with substantial real-estate holdings were thought to be prudent investments and that, in general, real estate was an excellent investment from 1970 through 1985. Therefore, the Trustee speculates that the previous trustee of the Plan acquired and held these shares for the Plan in the belief that companies with real-estate holdings were prudent investments.[6]

6. When the Trustee became trustee of the Plan, it was concerned about the concentration of Press shares owned by the Plan, particularly in light of the poor economic forecast for smaller towns dependent upon the depressed agricultural sector of the economy. In addition, the Trustee did not want the administrative burden and expensed of appraising closely held companies and would prefer to diversify the investments of the Plan. The Trustee states that there is virtually no market for the Press shares and that other Press shareholders have been notified and have no interest in purchasing additional shares of Press. The Trustee asserts that unless the Employer purchases the Press shares owned by the Plan, the Plan's assets could depreciate in value as no upturn in the real-estate market is anticipated. The proposed sales price will equal the fair market value of the Press shares on the date of the proposed sale, according to the Trustee. For these reasons, the Trustee believes it to be in the best interests of the Plan and its participants and beneficiaries to sell its holdings of Press shares and to reinvest the proceeds in other types of more liquid investments.

7. In summary, the applicant represents that the proposed transaction satisfies the exemption criteria set forth in section 408(a) of the Act because: (a) The proposed transaction is a one-time cash transaction; (b) the proposed sales price will equal the fair market value of the shares on the date of the sale as determined by the Trustee; (c) the Plan will pay no commission or other expenses relating to the proposed sale; and (d) the Trustee, who is not related to the Employer, its principals or affiliates, believes the proposed sale will spare the Plan from risk of loss and will permit the Plan to diversify further by investing in more liquid assets.

For Further Information Contact: Mrs. Miriam Freund of the Department, telephone (202) 523-8194. (This is not a toll-free number.)

[6] The Department is expressing no opinion herein as to whether or not the continued holding by the Plan (or any of the other plans mentioned in 2, above) of shares of Press constituted either a prohibited transaction under section 406 of the Act or a violation of any of the other fiduciary responsibility provisions of Part 4, Subtitle B, of Title I of the Act.

John A. Colglazier Self Employed Retirement Plan (the Plan) Located in San Antonio, Texas

[Application No. D-6626]

Proposed Exemption

The Department is considering granting an exemption under the authority of section 4975(c)(2) of the Code and in accordance with the procedures set forth in Rev. Proc. 75-26 (1975 C.B. 772). If the exemption is granted the sanctions resulting from the application of section 4975 of the Code, by reason of section 4975(c)(1) (A) through (E) of the Code shall not apply to the proposed cash sale by the Plan of a parcel of unimproved real property (the Property) located in San Antonio, Texas to John A. Colglazier (Mr. Colglazier), a disqualified person with respect the Plan;[7] provided that the cash received from the proposed sale is no less than the fair market value of the Property on the date of the sale.

Summary of Facts and Representations

1. The Plan is a defined contribution plan adopted on February 6, 1986, under a standardized master plan and trust agreement sponsored by RepublicBank Dallas, N.A., as a successor plan to a plan originally established March 13, 1983. RepublicBank San Antonio, N.A. serves as the trustee for the Plan. Mr. Colglazier, a self employed sole proprietor and the sole participant in the Plan, is engaged in the commercial and investment real estate business in San Antonio, Texas. The total Plan assets as of December 31, 1985, were approximately $294,636.

2. The Property consists of 1.0307 acres of unimproved land located in the northeast corner of the intersection of Mesquite and Duval Streets in San Antonio, Bexar County, Texas. The Plan acquired the Property on October 1, 1985, from Mr. William Cole Butler, an unrelated third party, for a purchase price of $2.80 per square foot plus $101 in charges for a total of $126,093.94. Also, the Plan has incurred engineering fees with respect to the Property in the amount of $628.41. The Property as of December 31, 1985, constituted approximately 42% of the assets of the Plan.

3. On February 6, 1986, Mr. Richard L. Dugger, MAI (Mr. Dugger) assisted by Mr. Bobby G. Mealer (Mr. Mealer), real

[7] Since Mr. Colglazier is a sole proprietor and the only participant in the Plan there is no jurisdiction under Title I of the Employee Retirement Income Security Act (the Act) pursuant to 29 CFR 2510.3-3(b). However, there is jurisdiction under Title II of the Act pursuant to section 4975 of the Code.

estate consultants and appraisers associated with Love & Dugger located in San Antonio, Texas, valued the property at approximately $146,000. Both Mr. Dugger and Mr. Mealer verify their independence in that they have no present or prospective interest in the Property nor any personal interest or bias with respect to the parties involved. It is represented that neither their employment nor the fee for the appraisal was contingent upon the valuation placed on the Property. Mr. Dugger is qualified in that he has been engaged since 1969 in appraising commercial, industrial, and residential real property, and farm and ranch lands in San Antonio, Texas. Mr. Dugger is certified under the voluntary continuing education program of the American Institute of Real Estate Appraisers and has attended various advanced residential appraisal courses in addition to teaching a course on the principles of real estate appraisal at San Antonio College. Mr. Dugger's professional affiliations include membership in the National Association of Realtors, the Society of Real Estate Appraisers, and the Texas Association of Realtors.

4. Mr. Colglazier is seeking an exemption from the prohibited transaction provisions of section 4975 of the Code to permit him to purchase the Property from the Plan for cash in the amount of the higher of the fair market value of the Property or $146,000. It is represented that the Plan will incur no fees, commissions, or other costs as a result of the sale. Mr. Colglazier states that the Plan originally acquired the Property to hold for long term appreciation, but that due to the depressed economic conditions in the real estate market in the San Antonio area, it would be in the Plan's best interest to sell the Property.

Mr. Colglazier represents that the Property is not near any other land which he owns, and at the time the Plan purchased the Property, he had the financial ability to purchase the Property himself. Mr. Colglazier states that the sale of the Property to him would result in a profit to the Plan which would be in the best interest of the Plan. It is represented that the proceeds, from the sale would be invested in other assets.

5. In summary, Mr. Colglazier represents that the proposed transaction satisfies the criteria for exemption under section 4975(c)(2) of the Code because:

(a) The sale of the Property will be a one-time transaction for cash;

(b) No fees, commissions, or other costs will be incurred by the Plan as a result of the sale;

(c) The Plan will sell the Property at its fair market value as determined by a qualified, independent appraiser; and

(d) The Plan will realize profit from the sale of the Property which the Plan will be able to invest in other assets.

Notice to Interested Persons

Because Mr. Colglazier is the applicant as well as the only participant in the Plan, it has been determined that there is no need to distribute the notice of pendency to interested persons. Comments and requests for a hearing must be received by the Department within 30 days of the date of publication of this notice of proposed exemption.

For Further Information Contact: Ms. Angelena C. Le Blanc of the Department, telephone (202) 523-8196. (This is not a toll-free number).

General Information

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of the Act and/or section 4975(c)(2) of the Code does not relieve a fiduciary or other party in interest or disqualified person from certain other provisions of the Act and/or the Code, including any prohibited transaction provisions to which the exemption does not apply and the general fiduciary responsibility provisions of section 404 of the Act, which among other things require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan an in a prudent fashion in accordance with section 404(a)(1)(B) of the Act; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries;

(2) Before an exemption may be granted under section 408(a) of the Act and/or section 4975(c)(2) of the Code, the Department must find that the exemption is administratively feasible, in the interests of the plan and of its participants and beneficiaries and protective of the rights of participants and beneficiaries of the plan; and

(3) The proposed exemptions, if granted, will be supplemental to, and not in derogation of, any other provisions of the Act and/or the Code, including statutory or administrative exemptions and transitional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction.

(4) The proposed exemptions, if granted, will be subject to the express condition that the material facts and representations contained in each application are true and complete, and that each application accurately describes all material terms of the transaction which is the subject of the exemption.

Signed at Washington, DC, this 29th day of May 1986.

Elliot I. Daniel,

Assistant Administrator for Regulations and Interpretations, Pension and Welfare Benefits Administration, U.S. Department of Labor.

[FR Doc. 86-12456 Filed 6-2-86; 8:45 am]

BILLING CODE 4510-29-M

Advisory Council on Employee Welfare and Pension Benefit Plans; Meeting

Pursuant to section 512 of the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. 1142, a public meeting of the Advisory Council on Employee Welfare and Pension Benefit Plans will be held at 9:30 a.m., on Thursday, June 12, 1986, in Conference Room N-3437D, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC.

The purpose of the meeting is to allow the Council additional time to deliberate the Termination Task Report on Pension Plan Terminations with Asset Reversions.

Signed at Washington, DC, this 28th day of May, 1986.

Dennis M. Kass,

Assistant Secretary, Pension and Welfare Benefits Administration.

[FR Doc. 86-12358 Filed 6-2-86; 8:45 am]

BILLING CODE 4510-29-M

NATIONAL SCIENCE FOUNDATION

Advisory Committee for the Critical Engineering Systems Section; Meeting

The National Science Foundation announces the following advisory committee meeting:

Name: Advisory Committee for the Critical Engineering Systems Section.

Date and time: June 19, 1986 (8:30—5:00 p.m.) June 20, 1986 (9:00 a.m.—3:00 p.m.)

Place: State Plaza Hotel (Diplomat Room) 2117 E Street NW., Washington, DC.

Type of meeting: June 19—Open, June 20—Closed.

Contact person: Dr. Michael P. Gaus, Section Head, Critical Engineering Systems, Division of Fundamental Research for Emerging and Critical Engineering Systems, National Science Foundation, 1800 G Street NW., Room 1130, Washington, DC 20550 (Telephone: 202–357–9500).

Summary of minutes: May be obtained from Contact Person listed above.

Purpose of meeting: To provide advice and recommendations concerning fundamental research for critical engineering systems.

Agenda June 19—

- Review of Program Awards in the following Programs: Earthquake Hazard Mitigation, Environmental Engineering, Systems Engineering for Large Structures, Natural and Man-Made Hazard Mitigation.
- Current Plans and Program Goals.
- Future Thrust Areas and Activities.
- External Peer Oversight of the Earthquake Hazard Mitigation Program and the Environmental Engineering Program.

Reason for closing: External Peer Oversight. The Committee will review grant and declination jackets which contain the names of applicant institutions and principal investigators and privileged information contained in declined proposals. The meeting will also include a review of the peer review documentation pertaining to the applicant. These matters are within exemptions 4 and 6 of the Government in the Sunshine Act.

May 29, 1986.

M. Rebecca Winkler,

Committee Management Officer.

[FR Doc. 86–12364 Filed 6–2–86; 8:45 am]

BILLING CODE 7555–01–M

Advisory Committee for Science and Engineering Education (ACSEE); Meeting

In accordance with the Federal Advisory Committee Act, as amended, Pub. L. 92–463, the National Science Foundation announces the following meeting:

Name: Advisory Committee for Science and Education (ACSEE).

Date and time: Monday, June 23, 1986, 9:00 A.M.—5:00 P.M. Tuesday, June 24, 1986, 9:00 A.M.—3:00 P.M.

Place: Room 540, National Science Foundation, 1800 G Street, NW., Washington, DC 20550.

Type of meeting: Open.

Contact person: Dr. Bassam Z. Shakhashiri, Assistant Director for Science and Engineering Education, National Science Foundation, Washington, DC 20550 Telephone: (202) 357–9522.

Summary minutes: May be obtained from Dr. W. Frederick Oettle, Executive Secretary, ACSEE, National Science Foundation, Room 414, Washington, DC 20550.

Purpose of committee: To provide advice and recommendations concerning NSF support for science and engineering education.

Agenda: June 23–24, 1986

Review of FY 86 Programs and Initiatives.

Review External Peer Oversight Committee Reports (External Peer Oversight Committee—Informal Science Education Program, External Peer Oversight Committee—Research in Teaching and Learning Program, External Peer Oversight Committee—Graduate/Minority Fellowships Program)

Discussion of NSB Report on Undergraduate Science, Mathematics, and Engineering Education.

Discussion of FY 87 Budget Request and proposed Plans and initiatives.

Strategic planning for FY 88–92.

Review Contractor's Report on Middle School Science.

May 29, 1986.

M. Rebecca Winkler,

Committee Management Officer.

[FR Doc. 86–12365 Filed 6–2–86; 8:45 am]

BILLING CODE 7555–01–M

Forms Submitted for OMB Review

In accordance with the Paperwork Reduction Act and OMB Guidelines, the National Science Foundation is posting this notice of information collection that will affect the public.

Agency clearance officer: Herman G. Fleming, (202) 357–7340.

OMB desk officer: Cargos Tellez, (202) 395–7340.

Title: Survey to Assess the Current Level of Tribology Reseach and Development Activities in the United States.

Affected public: Business, Federal agencies, Non-profit insitutions, and Small businesses.

Number of responses: 4,000 responses; total of 1,000 burden hours.

Abstract: The Tribology Program was initiated a year ago at NSF. In order to determine the program direction, we are conducting this survey to asses the current level of activities in tribology at universities, industry, and Federal Labs. This information is essential in formulating future plans for growth of this important research field.

Dated: May 29, 1986.

Herman G. Fleming,

NSF Reports Clearance Officer.

[FR Doc. 86–12374 Filed 6–2–86; 8:45 am]

BILLING CODE 7555–01–M

NUCLEAR REGULATORY COMMISSION

Consumers Power Co.; Withdrawal of Applications for Amendments to Facility Operating License

[Docket No. 50–255]

The U.S. Nuclear Regulatory Commission (the Commission has granted the request of Consumers Power Company (the licensee)) for withdrawal of six applications for amendments to Provisional Operating License No. DPR–20 for the Palisades Plant located in Van Buren County, Michigan. The Commission issued Notices of Consideration of Issuance of Amendments which were published in the Federal Register. The dates of application, subject matter of the proposed changes, and Federal Register citations are as follows:

1. Application dated November 12, 1981, "NUREG–0737 Action Item III.D.1.1," published December 21, 1983 (48 FR 56501);

2. Application dated November 17, 1981, "Equipment and Sampling Tests," published October 26, 1983 (48 FR 49582);

3. Application dated June 25, 1982, "Primary Coolant Boron Concentration," published September 21, 1983 (48 FR 43136);

4. Application dated June 25, 1982, "Fire Protection System," published October 26, 1983 (48 FR 49582);

5. Application dated June 29, 1982, "Surveillance Containment Air Coolers," published September 2, 1983 (48 FR 43136); and

6. Application dated February 5, 1985, "Minimum Conditions for Criticality," published May 21, 1984 (50 FR 20975).

By letter dated March 5, 1986, the licensee withdrew its applications for the proposed amendments.

For further details with respect to this action, see (1) the applications for amendments dated November 12, 1981; November 17, 1981; June 25, 1982 (2); June 29, 1982; and February 5, 1985; (2) the licensee's letter dated March 5, 1986 withdrawing the applications for amendments; and (3) the Commission's letter granting the withdrawal dated May 28, 1986. All of the above documents are available for public inspection at the Commission's Public Document Room, 1717 H Street, NW., Washington, DC and at the Van Zoeren Library, Hope College, Holland, Michigan 49423.

Dated at Bethesda, Maryland, this 28th day of May, 1986.

For The Nuclear Regulatory Commission.

Ashok C. Thadani,

Director, PWR Project Directorate No. 8, Division of PWR Licensing-B.

[FR Doc. 86-12413 Filed 6-2-86; 8:45 am]

BILLING CODE 7590-01-M

Northern State Power Co. Environmenal Assessment and Finding of No Significant Impact

[Docket No. 50-263]

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of exemption from certain requirements of Section III.G of Appendix R to 10 CFR Part 50 to Northern States Power Company (the licensee) for Monticello Nuclear Generating Plant, located at the licensee's site in Wright County, Minnesota.

Environmental Assessment

Identification of Proposed Action

The proposed action would grant exemption from certain requirements of Section III.G of Appendix R to 10 CFR Part 50 which relates to fire protection features for ensuring that systems and associated circuits used to achieve and maintain safe shutdown are free of fire damage. The exemption is technical since the licensee must demonstrate that fire protection configurations meet the specific requirements of Section III.G or that alternate fire protection configurations can be justified by an acceptable fire hazard analysis.

The Need for the Proposed Action

The proposed exemption is needed because the features described in the licensee's request regarding the existing and proposed fire protection at the plant would result in a net benefit to the public health and safety that compensates for any decrease in safety that may result from the granting of this exemption request.

Environmental Impacts of the Proposed Action

The proposed exemption will provide a degree of fire protection such that there is no increase in the risk of fires at Monticello. Consequently, the probability of fires has not been increased and the post-fire radiological releases will not be greater than previously determined nor does the proposed exemption otherwise affect radiological plant effluents. Therefore, the Commission concludes that there are not significant radiological environmental impacts associated with the proposed exemption.

With regard to potential nonradiological impacts, the proposed exemption involves features located entirely within the restricted areas as defined in 10 CFR Part 20. It does not affect nonradiological plant effluents and has no other environmental impact. Therefore, the Commission concludes that there are no significant nonradiological environmental impacts associated with the proposed exemption.

The Commission has determined not to prepare an environmental impact statement for the proposed exemption.

Based upon the foregoing environmental assessment, we conclude that the proposed action will not have a significant effect on the quality of the human environment.

For further details with respect to this action, see the licensee's letters dated August 5, 1983 and February 21, 1986. These letters are available for public inspection at the Commission's Public Document Room, 1717 H Street, NW., Washington, DC, and at the Environmental Conservation Library, Minneapolis Public Library, 300 Nicollet Mall, Minneapolis, 55401.

Dated at Bethesda, Maryland, this 28th day of May 1986.

For The Nuclear Regulatory Commission.

John A. Zwolinski,

Director, BWR Project Directorate No. 1. Division of BWR Licensing,

[FR Doc. 86-12414 Filed 6-2-86; 8:45 am]

BILLING CODE 7590-01-M

PACIFIC NORTHWEST ELECTRIC POWER AND CONSERVATION PLANNING COUNCIL

Mainstream Passage Advisory Committee; meeting

AGENCY: The Pacific Northwest Electric Power and Conservation Planning Council (Northwest Power Planning Council).

ACTION: Notice of meeting.

Status: Open.

SUMMARY: The Northwest Power Planning Council hereby announces a forthcoming meeting of its Mainstem Passage Advisory Committee of the Mainstream Passage Advisory Committee to be held pursuant to the Federal Advisory Committee Act, 5 U.S.C. Appendix I, 1-4. Activities will include:

- Transportation study findings
- Bypass system development and schedules at mainstem Corps dams
- Report on FISHPASS model sensitivity analysis
- Other
- Public comment

DATE: June 6, 1986. 9:00 a.m.

ADDRESS: The meeting will be held in the Council's Meeting Room, 850 SW. Broadway, Suite 1100, Portland, Oregon.

FOR FURTHER INFORMATION CONTACT: Peter Paquet, 503-222-5161.

Edward Sheets,

Executive Director.

[FR Doc. 86-12320 Filed 6-2-86; 8:45 am]

BILLING CODE 000-00-M

PEACE CORPS

Submission of Public Use Forms Review Request to the Office of Management and Budget

SUMMARY: Pursuant to the Paperwork Reduction Act of 1981 (44 U.S.C. Chapter 35), The Peace Corps has submitted to the Office of Management and Budget a request to approve the use of the Peace Corps Partnership Donor Forms through June 1, 1989. The forms are completed voluntarily by those seeking additional information about the Partnership Program. The forms provide the name, organization, current address and current phone number of those people interested. This information is necessary for Peace Corps to continue to provide new project information on a regular basis to current or potential donors.

Information about the forms:

Agency address: Peace Corps, 806 Connecticut Avenue, NW., Washington, DC 20526.

Title: Peace Corps Partnership Donor Forms.

Type of Request: Renewal of approval of use.

Frequency of collection: On occassion.

General description of respondents: Random sampling of schools, businesses, civic organizations, corporations and individuals who have requested more information about the Partnership Program.

Estimated number of respondents: 4,000 annually.

Estimated hours for respondents to furnish information: Five minutes.

Comments: Comments on these forms should be directed to Francine Picoult, Desk Officer, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

A copy of these forms may be obtained from Nicole Vanasse, Peace Corps Partnership Program, Room M-1107, 806 Connecticut Avenue, NW., Washington, DC 20526. Ms. Vanasse

may be called on area code 202–254–8406. This is not a toll-free number.

This is not a request to which 44 U.S.C. 3504(h) applies.

This notice is issued in Washington, DC, on May 29, 1986.

Linda Rae Gregory,

Associate Director for Management.

[FR Doc. 86–12360 Filed 6–2–86; 8:45 am]

BILLING CODE 6051–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–23279; File No. SR–MCC–86–4]

Self-Regulatory Organizations; Proposed Rule Change by Midwest Clearing Corp. Relating to the Reorganization of the Board of Directors

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934, 15 U.S.C. 78s(b)(1), notice is hereby given that on March 24, 1986, the Midwest Clearing Corporation filed with the Securities and Exchange Commission the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Attached to the filing as Exhibit A is the text of proposed amendments to the Midwest Clearing Corporation's By-Laws.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in Sections (A), (B) and (C) below, of the most significant aspects of such statements.

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The proposed amendments will facilitate the election of a separate Board of Directors for MCC. In the past, the membership of the MCC Board of Directors has in practice been the same as that of the Midwest Stock Exchange (MSE) Board of Governors. This common directorship reflected MCC's origin as an MSE subsidiary.

MCC will continue to be a wholly-owned MSE subsidiary. However, in order to address more efficiently MCC's business operations and goals, a separate Board of Directors is desired.

The proposed rule change will establish an seventeen member MCC Board. The MCC Chairman and Vice-Chairman will be chosen from among the directors; the President will be an *ex officio* director. The remaining sixteen directors will be divided into three classes and elected in staggered terms.

The proposed amendments are consistent with Section 17A of the Securities Exchange Act of 1934, in that it provides for the fair representation of MCC's Participants in the selection of its directors and the administration of its affairs.

(B) Self-Regulatory Organization's Statement on Burden on Competition

The Midwest Clearing Corporation does not believe that any burdens will be placed on competion as a result of the proposed rule change.

(C) Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants or Others

Comments have neither been solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will: (A) by order approve the proposed rule change, or (B) institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-referenced self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by June 24, 1986.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Dated: May 29, 1986.

Shirley E. Hollis,

Acting Secretary.

[FR Doc. 86–12431 Filed 6–2–86; 8:45 am]

BILLING CODE 8010–01–M

[Release No. 34–23277; File No. SR–MSRB–86–8]

Self-Regulatory Organizations; Municipal Securities Rulemaking Board; Order Approving Proposed Rule Change

The Municipal Securities Rulemaking Board ("MSRB"), Suite 800, 1818 N Street, NW., Washington, DC 20036–2491, submitted on April 3, 1986, copies of a proposed rule change pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act") and Rule 19b–4 thereunder, to modify MSRB rule G–11(g) on syndicate practices to require syndicate managers to provide to syndicate members a written summary of allocations receiving priority over members' "take-down" orders within two business days after the date of the sale, rather than the ten business days as currently required by the rule. The proposed rule change also would require that information identifying persons placing group or related portfolio orders to which securities are allocated be provided to syndicate members at or before final settlement of the syndicate, rather than within 10 business days of the sale date as the rule currently requires.

Notice of the proposed rule change was given in Securities Exchange Act Release No. 23134 (51 FR 15565, April 24, 1986). No comments were received regarding the proposal.

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the

rules and regulations thereunder applicable to the MSRB, and, in particular, the requirements of Section 15B and the rules and regulations thereunder.

It is therefore ordered, pursuant to Section 19(b)(2) of the Act, that the proposed rule change is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Dated: May 28, 1986.

Shirley E. Hollis,

Acting Secretary.

[FR Doc. 86-12432 Filed 6-2-86; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 34-23278; File No. SR-OCC-86-11]

Self-Regulatory Organization; Proposed Rule Change by the Options Clearing Corp. Relating to Adjustments to the Terms of Outstanding Stock Options

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934, 15 U.S.C. 78s(b)(i) (the "Act"), notice is hereby given that on May 13, 1986, The Options Clearing Corporation filed with the Securities and Exchange Commission the proposed rule change as descried in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Options Clearing Corporation ("OCC") proposes to amend Article VI, Section 11 of its By-Laws to read in its entirety as set forth below. Italics indicate material proposed to be added and bracketing indicates material proposed to be deleted.

THE OPTIONS CLEARING CORPORATION

BY-LAWS

Article VI

Adjustments

Section 11. (*a*) Whenever there is [declared] a *dividend,* stock dividend, stock distribution, stock split, [or] reverse *stock* split, rights offering distribution, reorganization, recapitalization, [or] reclassification or similar event in respect of any underlying security, *or a merger, consolidation, dissolution or liquidation of the issuer of any underlying security,* the number of [outstanding] option contracts, the unit of trading, [and/or] the exercise price, *and the underlying security, or any of them,* with respect to all *outstanding* option contracts open for trading in that underlying security *may* [shall] be adjusted [,effective on the "ex-date" of the underlying security in the primary market,] in accordance with this section 11. [The adjusted exercise price shall be rounded to the nearest ⅛ of a dollar and the adjusted trading unit shall be rounded down to eliminate any fractional share. No adjustment shall be made for cash distributions made out of "earnings and profits" as that term is used in the Federal Internal Revenue Code.]

(b) All adjustments hereunder shall be made by the Securities Committee. The Securities Committee shall determine to make adjustments to reflect particular events in respect of an underlying security, and the nature and extent of any such adjustment, based on its judgment as to what is appropriate for the protection of investors and the public interest, taking into account such factors as fairness to holders and writers of option contracts on the underlying security, the maintenance of a fair and orderly market it options on the underlying security, consistency of interpretation and practice, efficiency of exercise settlement procedures, and the coordination with other clearing agencies of the clearance and settlement of transactions in the underlying security. The Securities Committee may, in addition to determining adjustments on a case-by-case basis, adopt statements of policy or interpretations having general application to specified types of events. Every determination by the Securities Committee pursuant to this Section 11 shall be within the sole discretion of the Securities Committee and shall be consclusive and binding on all investors and not subject to review subject only to the oversight of the Securities and Exchange Commission pursuant to section 19(b) of the Securities Exchange Act of 1934, as amended, with respect to statements of policy or interpretations adopted by the Securities Committee.

(c) It shall be the general rule that there will be no adjustments to reflect ordinary cash dividends or distributions paid by the issuer of the underlying security.

[(a)] *(d) It shall be the general rule that* [I] *in* the case of a stock dividend, stock distribution or stock split whereby one or more whole numbers of shares of the underlying security are issued *with* [in] respect to each outstanding share, each option contract covering that underlying security [outstanding prior to such event] shall be increased by the same number of additional option contracts as the number of shares issued with respect to each share of the underlying security, [and] the exercise price per share in effect immediately prior to such event shall be proportionately reduced[.] , *and* [T] *the* unit of trading [with respect to each option contract] shall remain the same.

[(b)] *(e) It shall be the general rule that* [I] *in* the case of a stock dividend, stock distribution or stock split whereby other than a whole number of shares of the underlying security is issued in respect of each outstanding share, the exercise price in effect immediately prior to such event shall be proportionately reduced, and conversely, in the case of a reverse stock split or combination of shares, the exercise price in effect immediately prior to such event shall be proportionately increased. Whenever the exercise price with respect to an option contract has been reduced or increased in accordance with this paragraph *(e)* [(b)], the unit of trading [with respect to the option contact] shall be proportionately increased or reduced, as the case may be. [If an adjusted unit of trading is rounded down to eliminate a fractional share, the adjusted exercise price shall be further adjusted, to the nearest ⅛ of a dollar, to reflect any diminution in the value of the option contract resulting from the elimination of the fractional share. No adjustment in the number of option contracts outstanding shall be made on account of the happening of any of the events for which adjustments are provided in this paragraph.]

[(c)] *(f) It shall be the general rule that* [I] *in* the case of any distribution made with respect to shares of *an* underlying *security* [securities], other than cash distributions *subject to paragraph (c)* [of the character referred to in the third sentence] of this section 11 and other than distributions for which adjustments are provided in paragraphs (*d*) [(a)] or (*e*) [(b)] of this section 11, *if an adjustment is determined by* the Securities Committee *to be* [of the Corporation (as hereinafter defined) shall determine whether an adjustment is] appropriate, [by reason of such event in the interest of fairness to holders and writers of option contracts. Whenever an adjustment is so determined to be appropriate, either] (i) the exercise price in effect immediately prior to such event shall be reduced by the value per share of the distributed property, in which event the [trading] unit *of trading* shall not be adjusted, or (ii) the *unit of* trading [unit] in effect immediately prior to such event shall be adjusted so as to include the amount of property distributed with respect to the number of shares of the underlying security represented by the *unit of* trading [unit] in effect prior to such adjustment, in which event the exercise price shall not be adjusted. The Securities Committee shall, *with respect to adjustments under this paragraph or any other paragraph of this section 11, have the authority to determine the value of distributed property.* [determine whether a given event for which adjustment is provided under this paragraph shall result in an adjustment under clause (i) or clause (ii) of the preceding sentence, and, with respect to adjustments under clause (i), it shall determine the value of the distributed property.]

[(d)] *(g)* In the case of any [reorganization, recapitalization, reclassification or similar] event [with respect to shares of underlying securities] for which adjustment is not provided in any of the foregoing paragraphs of this section 11, [or in the case of any event for which adjustment is provided in one of the foregoing paragraphs but is not considered by the Securities Committee to be appropriate under the circumstances,] the Securities Committee *may* [shall] make such adjustments, *if any,* [in the exercise price, trading unit or number of contracts] with respect to the option contracts affected by such event as *the Securities* [that] Committee

[in its sole discretion] determines [to be fair to the holders and writers of such option contracts].

(h) Adjustments pursuant to this section 11 shall as a general rule become effective in respect of option contracts outstanding on the "ex-date" established by the primary market for the underlying security.

(i) It shall be the general rule that (1) all adjustments of the exercise price of an outstanding option contract shall be rounded to the nearest ⅛ of a dollar, and all adjustments of the unit of trading shall be rounded down to eliminate any fraction, and (2) if the unit of trading is rounded down to eliminate a fraction, the adjusted exercise price shall be further adjusted, to the nearest ⅛ of a dollar, to reflect any diminution in the vaule of the option contract resulting from the elimination of the fraction.

(j) Notwithstanding the general rules set forth in paragraphs (c) through (i) of this section 11 or which may be set forth as interpretations and policies under this section 11, the Securities Committee shall have the power to make exceptions in those cases or groups of cases in which, in applying the standards set forth in paragraph (b) hereof, the Securities Committee shall determine such exceptions to be appropriate. However, the general rules shall be applied unless the Securities Committee affirmatively determines to make an exception in a particular case or group of cases.

[(e)] *(k)* The Securities Committee[, in exercising its functions pursuant to paragraphs (c) or (d) of this section 11 regarding adjustment of option contracts in an underlying security,] shall consist of *one* [two] designated representative[s] of each Exchange [on which option contracts in that underlying security are open for trading] and the Chairman of the Corporation. *In making a determination regarding the adjustment of outstanding option contracts on a particular underlying security, the action of an adjustment panel consisting of two designated representatives of each Exchange on which option contracts on that underlying security are open for trading (one of whom shall be such Exchange's representative on the Securities Committee) and the Chairman of the Corporation shall constitute the action of the Securities Committee.* The vote of a majority of the voting members of the Securities Committee, *or of any adjustment panel,* shall constitute the *determination* [action] of the *Securities* Committee *or such panel.* The Chairman of the Corporation shall not be a voting member of the Committee *or of any adjustment panel* except in the case of a tie vote, in which case the Chairman shall have the right to cast a vote to break the tie and shall, for such purpose, be deemed to be a voting member. [The members of the Securities Committee need not be Clearing Members or officers or directors of the Corporation.] The Securities Committee *or any adjustment panel* may transact its business by telephone. *Notwithstanding the foregoing provisions of this paragraph, the Chairman of the Corporation may designate any other officer of the Corporation, and any representative of an Exchange may designate any other representative of such Exchange, to serve in his place at any meeting of the Securities Committee or of any adjustment panel. In the event of such designation, the designee shall, for the purposes of such meeting, have all of the powers and duties under this Section 11 of the person designating him. Neither the Corporation nor any Exchange shall designate to serve on any adjustment panel (i) any Exchange member or Clearing Member, or any director, officer, partner, or employee of any Exchange member or Clearing Member, or (ii) any person who, to the knowledge of the self-regulatory organization designating such person, is the beneficial holder of a long or short position in option contracts as to which adjustment panel is to make a determination.*

. . . Interpretations and Policies:

.01 Cash dividends or distributions in an aggregate amount which does not exceed 10% of the market value (as of the close of trading on the declaration date) of the underlying security outstanding will as a general rule, be deemed to be "ordinary cash dividends or distributions" within the meaning of paragraph (c) of Section 11. The Securities Committee will determine on a case-by-case basis whether other cash dividens or distributions are "ordinary cash dividiens or distributions" or whether they are dividends or distributions for which an adjustment should be made. [The Chairman of the Corporation may designate any other officer of the Corporation to serve in his place at any meeting of the Securities Committee. In the event of such designation, the Chairman's designee shall, for the purposes of such meeting, have all of the powers and duties of the Chairman under Article VI, section 11(e) of thue By-Laws.]

.02 Adjustments will not ordinarily be made to reflect the issuance of so-called "poison pill" right that are not immediately exercisable, trade as a unit or automatically with the underlying security, and may be redeemed by the issuer. In the event such rights become exercisable, begin to trade separately from the underlying security, or are redeemed, the Securities Committee will determine whether an adjustment is appropriate.

.03 Adjustments will not be made to reflect a tender offer or exchange offer to the holders of the underlying security, whether such offer is made by the issuer of the underlying security or by a third person or whether the offer is for cash, securities or other property. This policy will apply without regard to whether the price of the underlying security may be favorably or adversely affected by the offer or whether the offer may be deedmed to be "coercive." Outstanding options ordinarily will be adjusted to reflect a merger, consolidation or similar event that becomes effective following the completion of a tender offer or exchange offer.

.04 Adjustments will not be made to reflect changes in the capital structure of an issuer where all of the underlying securities outstanding in the hands of the public (other than dissenters' shares) are not changed into another security, cash or other property. For example, adjustments will not be made merely to reflect the issuance (except as a distribution on an underlying security) of new or additional debt, stock, or options, warrants or other securities convertible into or exercisable for the underlying security, the refinancing of the issuer's outstanding debt, the repurchase by the issuer of less than all of the underlying securities outstanding, or the sale by the issuer of significant capital assets.

.05 When an underlying security is converted into a right toreceive a fixed amount of cash, such as in a merger, outstanding options will be adjusted to require the delivery upon exercise of cash in an amount per share equal to the conversion price. As a result of such adjustment, the value of all outstanding in-the-money opitons will become fixed, and all at-the-money and out-of-the-money options will become worthless.

.06 In the case of a corporate reorganization, reincorporation or similar occurrence by the issuer of an underlying security which results in an automatic share-for-share exchange of shares in the issuer for shares in the resulting company, the options on the underlying security will ordinarily be adjusted to require delivery upon exercise of a like number of units of the shares of the resulting company. Because the securities are generally exchanged only on the books of the issuer and the resulting company, and are not generally exchanged physically, deliverable shares will ordinarily include certificates that are denominated on their face as shares in the original issuer, but which, as a result of the corporate transaction, represent shares in the resulting company.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

It its filing with the Commission, the self-regulatory organization included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The proposed rule change would amend and restate Article VI, section 11 of OCC's By-Laws, which governs adjustments to the terms of outstanding option contracts.

A major purpose of the proposed rule change is to give the OCC Securities Committee more discretion to deal with novel securities and new types of corporate transactions not contemplated at the time when Article VI, Section 11

was drafted. The provisions of the amended By-Law are therefore framed as general rules, which the Securities Committee is empowered to override when it deems such action to be appropriate for the protection of investors and the public interest.

The present prohibition against adjusting for cash distributions made out of "earnings and profits," as defined in the Internal Revenue Code, would be eliminated. In some cases, the "earnings and profits" test has proven difficult or impossible to apply. More importantly, the inflexibility of the present rule could lead to inequities by preventing OCC from adjusting outstanding options in response to cash distributions that were extraordinary in source and amount, but were nonetheless chargeable against "earnings and profits" for tax purposes.

The proposed rule change would replace the outright prohibition in the present By-law with a general rule that there will be no adjustments for "ordinary" cash dividends or distributions. A stated policy thereunder would provide that cash dividends and distributions of up to 10% of the market value of the underlying security would generally be deemed to be "ordinary," so as not to call for an adjustment. The Securities Committee would evaluate larger distributions on a case-by-case basis.

Another purpose of the proposed rule change is to articulate the standard to be followed by the Securities Committee in making adjustment determinations. That standard is the Committee's judgment as to what is appropriate for the protection of investors and the public interest, taking into consideration such factors as the maintenance of fair and orderly markets, consistency of interpretation and practice, efficiency of exercise settlement procedures, and coordination with stock clearing agencies.

In addition, the rule change would make explicit a point that OCC believes to be implicit in the present By-Law—namely, that decisions of the Securities Committee are intended to be final, conclusive, and not subject to review. The purpose of that provision is to make it clear that the market may trade in reliance on announced adjustment determinations without the risk that such determinations may later be overturned, and that such determinations are conclusive and binding on investors.

Finally, the rule change would establish a standing Securities Committee (as distinct from the *ad hoc* panels convened to deal with specific transactions) consisting of the Chairman of OCC and one representative of each self-regulatory organization that maintains an options market. The standing Committee would have the power to adopt stated policies and interpretations having general application to recurrent types of transactions not specifically covered in the By-Law itself.

The proposed rule change also includes a number of stated policies relating to the interpretation and administration of the amended By-Law. In addition to the policy defining "ordinary" cash distributions, discussed above, there are policies reflecting OCC's historical practice of not adjusting for issuances of "poison pill" rights, for tender offers or exchange offers, or for changes in an issuer's capital structure not involving the alternation of the legal rights represented by outstanding securities. Other policies cover adjustments for cash mergers and for reincorporation mergers not involving the replacement of outstanding stock certificates.

The proposed rule change is consistent with the purposes and requirements of sections 6 and 17A of the Exchange Act because it would further the maintenance of fair and orderly markets and the protection of investors and the public interest by eliminating unduly restrictive language in OCC's By-Law governing adjustments that might impede equitable adjustments in certain extraordinary situations, by clarifying the provisions of that By-Law and the effect of determinations thereunder, and by publishing stated policies dealing with adjustments for certain recurrent types of transactions.

B. Self-Regulatory Organization's Statement on Burden on Competition

OCC does not believe that the filing will have any impact on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were not and are not intended to be solicited by OCC with respect to the filing, and none have been received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days if it finds such longer period to be appropriate and publishes its reasons for so finding, or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning for foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, NW., Washington, DC. Copies of such filing will also be available for inspection and copying at the principal office of the above-mentioned self-regulatory organization. All submissions should refer to the file number in the caption above and should be submitted by June 24, 1986.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.

Dated: May 28, 1986.

Shirley E. Hollis,

Acting Secretary.

[FR Doc. 86-12433 Filed 6-2-86; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and Opportunity for Hearing; Midwest Stock Exchange, Inc.

May 20, 1986.

The above named national securities exchange has filed applications with the Securities and Exchange Commission pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder, for unlisted trading privileges in the following stocks:

The First Australia Prime Income Fund, Inc. Common Stock, $.01 Par Value (File No. 7-8968).

United States Tobacco Company (Del.) Common Stock, $.50 Par Value (File No. 7-8969).

These securities are listed and registered on one or more other national

securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before June 11, 1986, written data, views and arguments concerning the above-referenced applications. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the applications if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintenance of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 86-12428 Filed 6-2-86; 8:45 am]

BILLING CODE 8010-01-M

Self-Regulatory Organizations; Applications for Unlisted Trading Privileges and Opportunity for Hearing; Philadelphia Stock Exchange, Inc.

May 20, 1986.

The above named national securities exchange has filed applications with the Securities and Exchange Commission pursuant to section 12(f)(1)(B) of the Securities Exchange Act of 1934 and Rule 12f-1 thereunder, for unlisted trading privileges in the following securities:

York International Corporation
Common Stock, $0.001 Par Value (File No. 7-8965)
Pilgrim Regional Bank Shares, Inc.
Common Stock, $.001 Par Value (File No. 7-8966)
Alfin Fragrances, Inc.
Common Stock, $.01 Par Value (File No. 7-8967)

These securities are listed and registered on one or more other national securities exchange and are reported in the consolidated transaction reporting system.

Interested persons are invited to submit on or before June 11, 1986, written data, views and arguments concerning the above-referenced application. Persons desiring to make written comments should file three copies thereof with the Secretary of the Securities and Exchange Commission, Washington, DC 20549. Following this opportunity for hearing, the Commission will approve the application if it finds, based upon all the information available to it, that the extensions of unlisted trading privileges pursuant to such applications are consistent with the maintanence of fair and orderly markets and the protection of investors.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.

Shirley E. Hollis,

Assistant Secretary.

[FR Doc. 86-12429 Filed 6-2-86; 8:45 am]

BILLING CODE 8010-01-M

[500-1]

Western State Production Co., Inc.; Order of Suspension of Trading

May 29, 1986.

It appears to the Securities and Exchange Commission that there is a lack of adequate current information concerning the affairs of Western State Production Co., Inc.

Therefore, it is ordered, pursuant to section 12(k) of the Securities Exchange Act of 1934, that trading in the securities of Western State Production Co., Inc., over-the-counter or otherwise, is suspended for the period from 10:00 a.m. (EST) on Thursday, May 29, 1986 through midnight (EST) on Saturday, June 7, 1986.

By the Commission.

Shirley Hollis,

Acting Secretary.

[FR Doc. 86-12430 Filed 6-2-86; 8:45 am]

BILLING CODE 8010-01-M

DEPARTMENT OF STATE

[CM-8/974]

Integrated Services Digital Network (ISDN) Joint Working Party and Study Group C of the U.S. Organization for the International Telegraph and Telephone Consultative Committee (CCITT); Meeting

The Department of State announces that the ISDN Joint Working Party and Study Group C of the U.S. Organization for the International Telegraph and Telephone Consultative Committee (CCITT) will meet on Wednesday, June 18, 1986 in the A and B Conference Rooms, 10th Floor, AT&T Building, 1120 20th Street, NW., Washington, DC. The meeting will begin at 9:30 a.m.

The agenda for the meeting is as follows:

1. Report on Meeting of CCITT Study Group XI;
2. Report on Rapporteurs Meeting of Study Group XVIII;
3. Consideration of contributions to meeting of CCITT Study Group XVIII (Geneva, June 30-July 18); and
4. Any other business.

Members of the general public may attend the meeting and join in the discussion, subject to the instructions of the Chairman. Admittance of public members will be limited to the seating available. All persons planning to attend the meeting should contact Mr. Ted DeHaas at (303) 497-3728.

Dated: April 29, 1986.

Earl Barbely,

Acting Director, Office of the Technical Standards and Development.

[FR Doc. 86-12408 Filed 6-2-86; 8:45 am]

BILLING CODE 4710-07-M

[CM-8/971]

Overseas Schools Advisory Council; Meeting

The Overseas Schools Advisory Council, Department of State, will hold its Annual Meeting on Wednesday, June 18, 1986, in Conference Room 1107, Department of State Buidling, Washington, DC.

Agenda items scheduled for discussion are as follows:

I. Welcome and Introduction of Participants.

II. Greetings from the Department of State.

III. Results of Surveys Concerning School Fund Raising Efforts and Reports Regarding Activities of Overseas Schools Regional Associations.

IV. Council's Program of Educational Assistance:

(a) Final Report of 1984 Program and Progress Report on 1985 Program.

(b) Council's Efforts in Organizing an Appreciation-Stewardship Conference and Securing Contribtions for 1986 Program.

(c) Report of Meeting with Exchange Directors of the Overseas Schools Regional Associations in San Francisco on February 18, 1986.

V. Council Communication with U.S. Corporations and Foundations.

VI. Other Business.

Access to the State Department is controlled, therefore members of the public desiring to attend the meeting should call Ms. Joyce Bruce, Office of Overseas Schools, Department of State, Washington, DC., Area Code 703-235-9600, prior to June 18. The public may participate in discussions at the Chairman's instructions.

Dated: May 14, 1986.

Ernest N. Mannino,

Executive Secretary, Overseas Schools Advisory Council.

[FR Doc. 86-12405 Filed 6-2-86; 8:45 am]

BILLING CODE 4710-07-M

[CM-8/972]

Shipping Coordinating Committee; Meeting

The National Committee for Prevention of Marine Pollution (NCPMP) (a subcommittee of the Shipping Coordinating Committee) will conduct an open meeting on July 2, 1986 at 9:30 AM in Room 2415 at Coast Guard Headquarters, 2100 Second Street, SW., Washington, DC.

The purpose of the meeting will be a general review of the agenda items to be considered at the Twenty-third session of the Marine Environment Protection Committee (MEPC) of the International Maritime Organization (IMO) to be held July 7-11, 1986. Proposed U.S. positions of MEPC agenda item issues will be discussed.

The major items of discussion will be the following:

1. Proposed revisions, with a view toward ratification of optional Annexes III, IV, and V of the International Conventioon of the Prevention of Pollution from Ships, 1973, as modified by the Protocal of 1978 relating thereto (MARPOL 73/78). The MEPC at is 22nd session agreed in principle to a revised text of Annex III (Regulations of the Prevention of Pollution by Harmful Substances Carried by Sea in Package Form) wich provides for implmentation of Annex III provisions through the International Maritime Dangerous Goods (IMDG) Code.

Discussions will focus on the impact of Annex III requirements on existing packaging, marking/labeling and stowage requirements under SOLAS and the IMDG Code for packaged dangerous goods which have been dtermined to be marine pollutants. The criteria for determining marine pollutants under Annex III will also be addressed.

2. Uniform interpretations of Annex I (Regulations for the Prevention of Pollution by Oil) and Annex II (Regulations for the Control of Pollution by Noxious Liquid Substances in Bulk) of MARPOL 73/78.

4. Enforcement of pollution conventions.

5. Inter-related work of other Committees and Subcommittees.

Following this meeting, at 1:30 PM the NCPMP will conduct a special meeting to ascertain the desirability of U.S ratification of Annex V (Regulations for the Prevention of Pollution by Garbage from ships) to MARPOL 73/78. Notice of this special NCPMP meeting was published in the Federal Register on April 18, 1986 (51 FR 13310).

Members of the public may attend both meetings up to the seating capacity of the rooms.

For further information of for documentation pertaining to the NCPMP meeting, contact either Lieutenant Commander D.B. Pascoe or Lieutenant G.T. Jones, U.S. Coast Guard Headquarters (G-WER-3), 2100 Second Street, SW., Washington, DC 20593; Tel: (202) 426-9573.

Dated: May 28, 1986.

Richard C. Scissors,

Chairman, Shipping Coordinating Committee.

[FR Doc. 86-12406 Filed 6-2-86; 8:45 am]

BILLING CODE 4710-07-M

Shipping Coordinating Committee, Subcommittee on Safety of Life of Sea, Working Group on Standards of Training and Watchkeeping; Meeting

The Working Group on Standards of Training and Watchkeeping of the Subcommittee on Safety of Life at Sea (SOLAS) will conduct an open meeting on July 23, 1986 at 10:00 AM in Room 6317 at Coast Guard Headquarters, 2100 Second Street, SW., Washington, DC.

The purpose of the meeting will be a general review of the agenda items for the 19th Session of the International Maritime Organization (IMO) Subcommittee on Standards of Training and Watchkeeping, scheduled for September 29—October 3, 1986.

Members of the public may attend up to the seating capacity of the room.

For further information contact John J. Hartke, U.S. Coast Guard Headquarters (G-MVP/12), 2100 Second Street, SW., Washington, DC 20593. Telephone: (202 426-2985.

Dated: May 28, 1986.

Richard C. Scissors,

Director, Shipping Coordinating Committee.

[FR Doc. 86-12407 Filed 6-2-86; 8:45 am]

BILLING CODE 4710-07-M

DEPARTMENT OF TRANSPORTATION

Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits; Week Ended May 23, 1986

Subpart Q Applications

The due date for answers, conforming application, or motions to modify scope are set forth below for each application, following the answer period DOT may process the application by expedited procedures, such procedures may consist of the adoption of a show-cause order, a tentative order, or in appropriate cases a final order without further proceedings, (see 14 CFR 302.1701 et. seq.).

Date filed	Docket No.	Description
May 23, 1986	44054	American Airlines, Inc., Wesley G. Kaldahl, P.O. Box 619616, Maryland 3B55, DFW Airport, Texas 75261. Renewal Application of American Airlines, Inc. pursuant to section 401 of the Act and Subpart Q of the Regulations applies for renewal of its cetificate of public convenience and necessity for Route 316 (Dallas/Ft. Worth-Rio de Janeiro/Sao Paulo, Brazil). Conforming Applications, Motions to Modify Scope and Answers may be filed by June 20, 1986.
May 23, 1986	44055	Japan Air Lines Company, Ltd., c/o Laurence A. Short, Short, Klein & Karas, P.C., Suite 303, 1101 Thirtieth Street, NW., Washington, DC 20007. Application of Japan Air Lines Company, Ltd. pursuant to section 402 of the Act and Subpart Q of the Regulations applies for an amendment of its Foreign Air Carrier Permit so as to authorized it to additionally engage in foreign air transportation of persons, property and mail between Tokyo, Japan and Atlanta, Georgia. Answers may be filed by June 20, 1986.
May 23, 1986	43771	All Nippon Airways, Co., Ltd., c/o James L. Devall, Zuckert, Scoutt, Rasenberger & Johnson, 888 17th Street, NW., Suite 600, Washington, DC 20006. Amendment No. 1 to the Application of All Nippon Airways Co., Ltd. pursuant to section 402 of the Act and Subpart Q of the Regulations, amends its application for foreign air carrier permit, in order that the application include a request for authority to engage in foreign air transportation over the following routes: Tokyo—Los Angeles Tokyo—Washington Answers may be filed by June 16, 1986.
May 23, 1986	42690	American Airlines, Inc., c/o Alfred V.J. Prather, Prather Seeger Doolittle & Farmer, 1600 M Street, NW., 7th Floor, Washington, DC 20036. Amendment No. 1 to the Application of American Airlines, Inc., amends its application for certificate of convenience and necessity for Route 137 (Segment 1: U.S.—Caribbean Points) to add authority between points in the United States and points in the British Virgin Islands.

Date filed	Docket No.	Description
		Answers may be filed by June 17, 1986.

Phyllis T. Kaylor,
Chief, Documentary Services Division.
[FR Doc. 86-12402 Filed 6-2-86; 8:45 am]
BILLING CODE 4910-62-M

Federal Highway Administration

Environmental Impact Statement: Nashua, NH

AGENCY: Federal Highway Administration, DOT.
ACTION: Notice of Intent.

SUMMARY: The Federal Highway Administration is issuing this notice to advise the public that an environmental impact statement will be prepared for a proposed project in the City of Nashua in New Hampshire.

FOR FURTHER INFORMATION CONTACT: (1) For the Federal Highway Administration (FHWA), William F. O'Donnell, Area Engineer, Telephone: (603) 224-3385, Federal Highway Administration, 55 Pleasant Street, Room 219, Concord, NH 03301, or Frederic C. Murphy, Chief, Environmental Services Section, Telephone: (603) 271-3791, The State of New Hampshire Department of Transportation, John O. Morton Building, Concord, NH 03301.

SUPPLEMENTARY INFORMATION: The FHWA in cooperation with the New Hampshire Department of Transportation and the City of Nashua, will prepare an environmental impact statement (EIS) on a proposal to provide traffic and air quality relief to the Nashua CBD in the vicinity of the current Main Street crossing of the Nashua River.

The proposed action is anticipated to include a new Nashua River bridge westerly of Main Street with approach roadways connecting downtown Nashua in the vicinity of West Hollis Street with Broad Street in the vicinity of Exit 6 on the F. E. Everett Turnpike. The proposed roadway would likely be a 4-lane controlled access facility of about 1.5 miles in length.

This improvement is considered necessary to accommodate projected traffic demand and to assist in the alleviation of carbon monoxide air quality violations documented along Main Street. Alternatives under consideration include:

1. Various locations of a new roadway and bridge,
2. Variations in the cross-section including number of lanes and degree of access control,
3. Improvements to the existing highway system, and
4. Taking no action.

The Scoping Process will consist of individual meetings with those agencies believed to have an interest in the study area and potential social, economic and environmental factors affected by the proposed action. These meetings will be initiated in July of 1986. A single formal scoping meeting of all agencies is not planned.

To ensure that the full range of issues related to this proposed action are addressed and all significant issues identified, comments and suggestions are invited from all interested parties. Comments and questions concerning these proposed actions and the EIS should be directed to the FHWA or the New Hampshire Department of Transportation personnel noted above.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Research, Planning and Construction. The provisions of OMB Circular No. A-95 regarding State and clearinghouse review of Federal and federally-assisted programs and projects apply to this program.)

Issued on: May 23, 1986.

Vincent F. Schimmoller,
Division Administrator, Concord, New Hampshire.
[FR Doc. 86-12357 Filed 6-2-86; 8:45 am]
BILLING CODE 4910-22-M

UNITED STATES INFORMATION AGENCY

United States Advisory Commission on Public Diplomacy; Meeting

A meeting of the U.S. Advisory Commission on Public Diplomacy will be held in New York City on June 11, 1986. The Commission will meet at the U.S. Mission to the United Nations, 799 U.N. Plaza, at 9:00 AM-2:00 PM to discuss public diplomacy programs with members of the U.S. delegation to the UN.

Please call Gloria Kalamets, (202) 485-2468, for further information.

Dated: May 29, 1986.

Charles N. Canestro,
Management Analyst, Federal Register Liaison.
[FR Doc. 86-12412 Filed 6-2-86; 8:45 am]
BILLING CODE 8230-01-M

UNITED STATES SENTENCING COMMISSION

Notice of Hearing

AGENCY: United States Sentencing Commission.
ACTION: Notice of Hearing.

SUMMARY: This notice announces that a hearing of the topic of Organizational Sanctions appropriate under sentencing guidelines in scheduled by the U.S. Sentencing Commission for Tuesday, June 10, 1986.

Date: June 10, 1986.
Time: 10 a.m.
Location: U.S. Sentencing Commission Hearing Room, 14th Floor of the North Office Tower at National Place, 1331 Pennsylvania Avenue, NW., Washington, DC 20004. Further Information: Contact Paul Martin, Communications Director, 1331 Pennsylvania Avenue, NW., Suite 1400, Washington, DC 20004, (202) 662-8800.

SUPPLEMENTARY INFORMATION: The U.S. Sentencing Commission was established under the Comprehensive Crime Control Act of 1984 and is an independent Commission in the Judicial Branch. The Commission is charged with developing a national sentencing policy for the federal courts, and pursuant to that, mandatory sentencing guidelines. The June 10 hearing, the Commission's third, will focus on the sanctions available and appropriate for the corporation, business, union or other organization convicted of a federal crime.

Written statements on this topic may be submitted to the U.S. Sentencing Commission, 1331 Pennsylvania Avenue, NW., Suite 1400, Washington, DC 20004. The hearing record will remain open for thirty days after the hearing for additional written submissions. All are invited to attend the hearing.

William W. Wilkins, Jr.,
Chairman.
[FR Doc. 86-12382 Filed 6-2-86; 8:45 am]
BILLING CODE 2210-01-M

VETERANS ADMINISTRATION

Agency Form Under OMB Review

AGENCY: Veterans Administration.
ACTION: Notice.

The Veterans Administration has submitted to OMB for review the

following proposal for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35). This document contains an extension and lists the following information: (1) The department or staff office issuing the forms, (1) the title of the form, (3) the agency number, if applicable, (4) how often the form must be filled out, (5) who will be required or asked to report, (6) an estimate of the number of responses, (7) an estimate of the total number of hours needed of fill out the form, and (8) an indication of whether section 3504(h) of Pub. L. 96–511 applies.

ADDRESSES: Copies of the form and supporting documents may be obtained from Nancy C. McCoy, Agency Clearance Officer (732), Veterans Administration, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 389–2146. Comments and questions about the items on the list should be directed to the VA's OMB Desk Officer, Dick Eisinger, Office of Management and Budget, 726 Jackson Place, NW., Washington, DC 20503, (202) 395–7316.

DATES: Comments on the information collection should be directed to the OMB Desk Officer within 60 days of this notice.

Dated: May 28, 1986.

By direction of the Administrator:

David A. Cox,

Associate Deputy Administrator for Management.

Extension

1. Department of Veterans Benefits.
2. Monthly Record of Training and Wages.
3. VA Form 20–1905c.
4. Monthly.
5. Individuals or households; Businesses or other for-profit; Small businesses or organizations.
6. 4,800 responses.
7. 1,200 hours.
8. Not applicable.

[FR Doc. 86–12390 Filed 6–2–86; 8:45 am]
BILLING CODE 8320–01–M

Sunshine Act Meetings

Federal Register
Vol. 51, No. 106
Tuesday, June 3, 1986

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

CONTENTS

1

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., June 10, 1986.

PLACE: 2033 K Street, NW., Washington, DC, 8th Floor Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:
Enforcement Matters.

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.
[FR Doc. 86–12507 Filed 5–30–86; 11:35 am]
BILLING CODE 6351–01–M

2

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., June 17, 1986.

PLACE: 2033 K Street, NW., Washington, DC, 5th Floor Hearing Room.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Applications of the Chicago Mercantile Exchange for designation as a contract market in 5 year, 10 year and 20 year United States Treasury Strips
Applications of the Chicago Board of Trade for designation as a contract market in Zero Coupon Treasury Bond futures and Zero Coupon Long Term-Note futures
Application of the Chicago Mercantile Exchange for designation in Canadian Dollar Options

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb. 254–6314.

Jean A. Webb,
Secretary of the Commission.
[FR Doc. 86–12508 Filed 5–30–86; 11:35 am]
BILLING CODE 6351–01–M

3

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., June 24, 1986.

PLACE: 2033 K Street, NW., Washington, DC, 8th Floor Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED:
Enforcement Matters.

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.
[FR Doc. 86–12509 Filed 5–30–86; 11:36 am]
BILLING CODE 6351–01–M

4

COMMODITY FUTURES TRADING COMMISSION

TIME AND DATE: 10:00 a.m., June 27, 1986.

PLACE: 2033 K Street, NW., Washington, DC, 8th Floor Conference Room.

STATUS: Closed.

MATTERS TO BE CONSIDERED: Sales Practice Reviews.

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 254–6314.

Jean A. Webb,
Secretary of the Commission.
[FR Doc. 86–12510 Filed 5–30–86; 11:36 am]
BILLING CODE 6351–01–M

5

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: 19656, dated May 30, 1986.

PREVIOUSLY ANNOUNCED TIME AND DATE OF MEETING: 2:00 p.m. (eastern time), Monday, June 9, 1986.

CHANGE IN THE MEETING: The following matter has been added to the open portion of the meeting.

"Proposed Revisions to the Federal Sector Complaint Processing Regulations at 29 CFR Part. 1613"

CONTACT PERSON FOR MORE INFORMATION: Cynthia C. Matthews, Executive Officer, Executive Secretariat, at (202) 634–6748.

Dated: May 30, 1986.

Cynthia C. Matthews,
Executive Officer, Executive Secretariat.
[FR Doc. 86–12554 Filed 5–30–86; 3:23 pm]
BILLING CODE 6750–06–M

6

FARM CREDIT ADMINISTRATION

SUMMARY: Notice is hereby given, pursuant to the Government in the Sunshine Act (5 U.S.C. 552b(e)(3)), of the forthcoming first meeting of the Farm Credit Administration Board.

DATE AND TIME: The meeting is scheduled to be held at the offices of the Farm Credit Administration in McLean, Virginia, on June 5, 1986, from 11:00 a.m. until 1:00 p.m., or such time as the Board may conclude its business.

FOR FURTHER INFORMATION CONTACT: Kenneth J. Auberger, Secretary to the Farm Credit Administration Board, 1501 Farm Credit Drive, McLean, VA 22102–5090, (703–883–4010).

ADDRESS: Farm Credit Administration, 1501 Farm Credit Drive, McLean, VA 22102–5090.

SUPPLEMENTARY INFORMATION: The meeting of the Farm Credit Administration Board will be open to the public (limited space available), except as the Board may determine to conduct one or more portions of the meeting in closed session. The matters scheduled to be considered at the meeting are:

1. Adoption of Rules for the Transaction of Business of the Farm Credit Administration Board.
2. Regulations.

Final

Section 611.1142(h)—Farm Credit System Capital Corporation; General Corporate Powers
Part 611—Farm Credit System Capital Corporation; Organization—Extension of Comment Period for Additional 30 days
Part 620—Disclosure to Stockholder Requirements (Amendments)
Part 622—Rules of Practice and Procedure
Part 623—Practice Before the Farm Credit Administration

Proposed

Part 615—Subpart H and Subpart I—Capital Adequacy of Banks and Associations

Dated: May 30, 1986.

Frank W. Naylor, Jr.,

Chairman, Farm Credit Administration Board.

[FR Doc. 86-12552 Filed 5-30-86; 3:19 pm]

BILLING CODE 6705-01-M

7

FEDERAL COMMUNICATIONS COMMISSION

May 29, 1986.

The Federal Communications Commission will hold an Open Meeting on the subjects listed below on Thursday, June 5, 1986, which is scheduled to commence at 9:30 a.m., in Room 856, at 1919 M Street NW., Washington, DC.

Agenda, Item No., and Subject

General—1—Title: Amendment of Subpart H. Part 1 of the Commission's Rules and Regulations Relating to Ex Parte Communications and Presentations in Commission Proceedings. Summary: FCC proposes changes to Subpart H, Part 1 of the Commission's rules relating to ex parte communications and presentations governing Commission proceedings.

Mass Media—1—Title: Petitions to deny applications for transfer of control of RCA Corporation and its subsidiaries, including National Broadcasting Company, from its stockholders to the General Electric Company, filed by Wilbert A. Tatum, Western Slope Communications, Ltd., Aspen Channel 3 Television, Inc., and Anthony R. Martin-Trigona. An informal objection was filed by John S. Shipp, III. Summary: The Commission will consider the petitions to deny filed by Tatum, Western Slope, Aspen and Martin-Trigona, in which they allege that the proposed merger violates Sections 222 and 314 of the Communications Act, that RCA may be in violation of Sections 317 and 508 of the Act, that NBC has violated § 73.658(b) of the Commission's Rules by refusing a new work affiliation, and that GE does not have the requisite character qualifications to be a licensee. The Commission will also consider the informal objection filed by Shipp, which alleges that NBC has engaged in racial discrimination.

This meeting may be continued the following work day to allow the Commission to complete appropriate action.

Additional information concerning this meeting may be obtained from Judith Kurtich, FCC Office of Congressional and Public Affairs, Telephone number (202) 254-7674.

Issued: May 29, 1986.

Federal Communications Commission.

William J. Tricarico,

Secretary.

[FR Doc. 86-12484 Filed 5-30-86; 9:53 am]

BILLING CODE 6712-01-M

8

FEDERAL DEPOSIT INSURANCE CORPORATION

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given that the following matter will be withdrawn from the "discussion agenda" for consideration at the open meeting of the Board of Directors of the Federal Deposit Insurance Corporation scheduled to be held at 9:00 a.m. on Tuesday, June 3, 1986, in the Board Room on the sixth floor of the FDIC Building located at 550—17th Street, NW., Washington, DC.:

Memorandum and resolution regarding petitions to reconsider certain prohibitions governing securities subsidiaries and affiliates contained in Part 337 of the Corporation's rules and regulations, entitled "Unsafe or Unsound Banking Practices."

Requests for further information concerning the meeting may be directed to Mr. Hoyle L. Robinson, Executive Secretary of the Corporation, at (202) 898-3813.

Dated: May 29, 1986.

Federal Deposit Insurance Corporation.

Hoyle L. Robinson,

Executive Secretary.

[FR Doc. 86-12506 Filed 5-30-86; 11:35 am]

BILLING CODE 6714-01-M

9

FEDERAL MARITIME COMMISSION

TIME AND DATE: 11:00 a.m., June 3, 1986.

PLACE: Hearing Room One, 1100 L Street NW., Washington, DC 20573.

STATUS: Closed.

MATTERS TO BE CONSIDERED: American Association of Cruise Passengers v. Cunard Line, Ltd., et al., Civil Action No. 86-0571, United States District Court for the District of Columbia.

CONTACT PERSON FOR MORE INFORMATION: Tony Kominoth, Assistant Secretary, (202) 523-5725.

Tony Kominoth,

Assistant Secretary.

[FR Doc. 86-12511 Filed 5-30-86; 11:35 am]

BILLING CODE 6730-01-M

10

FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS

TIME AND DATE: 2:15 p.m., Thursday, June 5, 1986.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (applintments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

2. Any items carried forward from a previously announced meeting.

CONTACT PERSONS FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: May 29, 1986.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 86-12463 Filed 5-30-86; 9:19 am]

BILLING CODE 6210-01-M

11

MERIT SYSTEMS PROTECTION BOARD

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: Vol. 51, 18864, May 22, 1986.

PREVIOUSLY ANNOUNCED TIME AND DATE: Tuesday, June 3, 1986, 10:30 a.m.

PLACE: Eighth Floor, 1120 Vermont Averue, NW., Washington, DC.

CHANGES IN THE MEETING: The hearing scheduled for June 3, 1986, *Woods* v. *U.S. Customs Service*, MSPB Docket No. PH07528310145 is rescheduled to Thursday, June 26, 1986 at 10:00 a.m.

CONTACT PERSON FOR MORE INFORMATION: Robert E. Taylor, Clerk of the Board (202) 653-7200.

Dated: May 30, 1986.

Robert E. Taylor,

Clerk of the Board.

[FR Doc. 86-12549 Filed 5-30-86; 2:36 pm]

BILLING CODE 7400-01-M

12

NATIONAL TRANSPORTATION SAFETY BOARD

TIME AND DATE: 9:00 a.m., Tuesday, June 10, 1986.

PLACE: NTSB Board Room, Eighth Floor, 800 Independence Avenue, SW., Washington, DC 20594.

STATUS: Open.

MATTERS TO BE CONSIDERED:

1. *Marine Accident Report:* Collision between U.S. Passenger Vessel MISSISSIPPI

QUEEN and U.S. Towboat CRIMSON GLORY in the Mississippi River near Donaldsonville, Louisiana, December 12, 1985.

2. *Highway Accident Report:* Tractor Semitrailer Station Wagon Runaway Collision and Fire in Van Buren, Arkansas, June 21, 1985.

3. *Marine Accident Report:* Grounding of the U.S. Passenger Vessel PILGRIM BELLE, at Sow and Pigs Reef, Vineyard Sound, Massachusetts, July 28, 1985.

CONTACT PERSON FOR MORE INFORMATION: H. Ray Smith, (202) 382–6525.

Catherine T. Kaputa,

Federal Register Liaison Officer.

May 30, 1986.

[FR Doc. 86–12528 Filed 6–2–86; 1:30 pm]

BILLING CODE 7533–01–M

13

NATIONAL TRANSPORTATION SAFETY BOARD

TIME AND DATE: 3:00 p.m., Wednesday, June 25, 1986.

PLACE: NTSB Board Room, Eighth Floor, 800 Independence Avenue, SW., Washington, DC 20594.

STATUS: Open.

MATTERS TO BE CONSIDERED: Briefing by the Federal Aviation Administration regarding Project SAFE; a comprehensive review of the FAA's safety inspection system (public report published on September 20, 1985, entitled "Project SAFE: A Blueprint for Flight Standards")

CONTACT PERSON FOR MORE INFORMATION: H. Ray Smith, (202) 382–6525.

Catherine T. Kaputa,

Federal Register Liaison Officer.

May 30, 1986.

[FR Doc. 86–12529 Filed 6–2–86; 1:30 pm]

BILLING CODE 7533–01–M

14

NUCLEAR REGULATORY COMMISSION

DATE: Weeks of June 2, 9, 16, and 23, 1986.

PLACE: Commissioners' Conference Room, 1717 H Street NW., Washington, DC.

STATUS: Open and Closed.

MATTERS TO BE CONSIDERED:

Week of June 2

Thursday, June 5

2:00
Meeting with Advisory Committee on Reactor Safeguards (ACRS) on GESSAR II (Open/Portion may be closed—Ex. 3 & 4)

3:30 p.m.
Affirmation/Discussion and Vote (Public Meeting)
a. Uranium Millers' "Motion to Amend Order Establishing Briefing Schedule"
b. Litigation of Shoreham Emergency Planning Issues (Tentative)

Friday, June 6

10:00 a.m.
Briefing by Staff on Status of TVA (Open/Portion may be Closed—Ex. 5 & 7)

2:00 p.m.
Briefing by Davis-Besse Ad Hoc Review Group (Public Meeting)

Week of June 9—Tentative

Tuesday, June 10

2:00 p.m.
Discussion of Pending Investigations (Closed—Ex. 5 & 7)

Wednesday, June 11

11:00 a.m.
Periodic Meeting with Advisory Panel for the Decontamination of TMI–2 (Public Meeting)

2:00 p.m.
Briefing on Status of EEO Program (Public Meeting)

Thursday, June 12

2:00 p.m.
Briefing on Restart of San Onofre-1 (Public Meeting)

3:30 p.m.
Affirmation Meeting (Public Meeting) (if needed)

Week of June 16—Tentative

Wednesday, June 18

10:00 a.m.
Discussion/Possible Vote on Safety Goals (Public Meeting)

2:00 p.m.
Briefing on La Crosse Request for an Exemption to Reduce Primary Property Value Insurance (Public Meeting)

3:30 p.m.
Affirmation Meeting (Public Meeting) (if needed)

Week of June 23—Tentative

Wednesday, June 25

2:00 p.m.
Discussion/Possible Vote on Full Power Operating License for Hope Creek (Public Meeting)

Thursday, June 26

2:00 p.m.
Affirmation Meeting (Public Meeting) (if needed)

ADDITIONAL INFORMATION: Briefing on IAEA General Meeting on the Chernobyl Incident (Public Meeting) was held on May 28.

TO VERIFY THE STATUS OF MEETINGS CALL (RECORDING): (202) 634–1498.

CONTACT PERSON FOR MORE INFORMATION: Robert McOsker (202) 634–1410.

Andrew L. Bates,

Office of the Secretary.

May 29, 1986.

[FR Doc. 86–12555 Filed 5–30–86; 3:45 PM

BILLING CODE 7590–01–M

15

PACIFIC NORTHWEST ELECTRIC POWER AND CONSERVATION PLANNING COUNCIL

ACTION: Notice of meeting to be held pursuant to the Government in the Sunshine Act (5 U.S.C. 552b).

STATUS: Open. The Council also will hold an executive session to discuss pending litigation.

TIME AND DATE: June 10–12, 1986, 9:00 a.m.

PLACE: Elkhorn Lodge at Sun Valley, Ketchum, Idaho.

MATTERS TO BE CONSIDERED:

- Staff Presentation on Salmon and Steelhead Planning Paper
- Staff Presentation on Research Issue Paper
- Preliminary Council Action on Hydropower Responsiblity for Salmon and Steelhead Losses in the Columbia River Basin
- Briefing and Public Comment on Applications to Amend Columbia River Fish and Wildlife Program: [1]
  - —Water budget accounting (Application 304(a)(2)(CBFWC)
  - —Spill levels (Applications 403/404(b)/CBFWC and 1504/CBFWC)
  - —Transportation (Applications 404(b)(17)/COE and 1504(32.2)/COE)
  - —Intertie access (Application 1504 (42.3)/CBFWC–5)
  - —Institutional processes (Institutional portions of applications 304(a)–(d)/CBFWC, 304(b)–(c)/CBFWC, 403/404(b)/CBFWC, 1504/CBFWC)
- Public Comment and Council Decision on Draft Process for Evaluating Petitions to Enter Rulemaking [2]
- Public Comment on Impact of Oil and Gas Price Changes on the Energy Plan
- Staff Presentation and Public Comment on Council FY 87–88 Budget
- Council Business.

Public comment will follow each item.

FOR FURTHER INFORMATION CONTACT: Ms. Bess Atkins, (503) 222–5161, or toll-

[1] Applicants will be asked to explain their applications and respond to questions from the Council members. Opportunities for public comment will follow. For copies of the applications listed, call Judy Allender in the Council offices (1–800–222–3355 in Idaho, Montana and Washington, and 1–800–452–2324 in Oregon only).

[2] It is difficult to predict how long the fish and wildlife agenda items will take, especially the presentations and public comments on amendment applications. The Council will not take up the power planning or budget agenda items (#5, 6 and 7) before 1:30 p.m. on June 11.

free 1–800–222–3355 (Montana, Idaho or Washington) or 1–800–452–2324 (Oregon).

Edward Sheets,

Executive Director.

[FR Doc. 86–12493 Filed 5–30–86; 11:35 am]

BILLING CODE 000–000–M

Federal Register

Tuesday
June 3, 1986

Part II

Department of the Interior

Fish and Wildlife Service

Department of Commerce

National Oceanic and Atmospheric Administration

50 CFR Part 402

Interagency Cooperation—Endangered Species Act of 1973, as Amended; Final Rule

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 402

Interagency Cooperation—Endangered Species Act of 1973, as Amended; Final Rule

AGENCIES: Fish and Wildlife Service, Interior; National Marine Fisheries Service, National Oceanic and Atmospheric Administration, Commerce.

ACTION: Final rule.

SUMMARY: This final rulemaking establishes the procedural regulations governing interagency cooperation under section 7 of the Endangered Species Act of 1973, as amended (the "Act"). The Act requires Federal agencies, in consultation with and with the assistance of the Secretaries of the Interior and Commerce, to insure that their actions are not likely to jeopardize the continued existence of endangered or threatened species or result in the destruction or adverse modification of the critical habitat of such species. The Endangered Species Act Amendments of 1978, 1979, and 1982 (the "Amendments") changed the consultation requirements of section 7. This final rulemaking amends the existing rules governing section 7 consultation by implementing the changes required by the Amendments and by incorporating other procedural changes designed to improve interagency cooperation.

EFFECTIVE DATE: July 3, 1986.

FOR FURTHER INFORMATION CONTACT: Marvin E. Moriarty, Acting Chief, Office of Endangered Species, U.S. Fish and Wildlife Service, Department of the Interior, Washington, D.C. 20240 (703–235–2771); or Charles Karnella, Protected Species Division, Office of Protected Species and Habitat Conservation, National Marine Fisheries Service, National Oceanic and Atmospheric Administration, Department of Commerce, Washington, D.C. 20235 (202–634–7461).

SUPPLEMENTARY INFORMATION:

Background

On January 4, 1978, the Department of the Interior, through the United States Fish and Wildlife Service (FWS), and the Department of Commerce, through the National Marine Fisheries Service (NMFS), established procedures for the Act's consultation process by implementing the interagency cooperation requirements of section 7 (50 CFR Part 402, "1978 rule"). The consultation process is designed to assist Federal agencies in complying with the requirements of section 7 and provides such agencies with advice and guidance from the Secretary on whether an action complies with the substantive requirements of section 7.

The Secretaries of the Interior and Commerce (the "Secretary") share responsibilities for conducting consultations pursuant to section 7 of the Act. Generally, marine species are under the jurisdiction of the Secretary of Commerce and all other species are under the jurisdiction of the Secretary of the Interior. Authority to conduct consultations has been delegated by the Secretary of the Interior to the Director of the FWS and by the Secretary of Commerce to the Assistant Administrator for Fisheries, NMFS, National Oceanic and Atmospheric Administration.

Section 7(a)(1) of the Act authorizes Federal agencies, in consultation with and with the assistance of the Secretary of the Interior or Commerce, depending on the species involved, to utilize their resources in furtherance of the purposes of the Act by carrying out programs for the conservation of endangered species and threatened species ("listed species") listed pursuant to section 4 of the Act.

Section 7(a)(2) of the Act requires Federal agencies, in consultation with and with the assistance of the Secretary, to insure that any action authorized, funded, or carried out by such agency is not likely to jeopardize the continued existence of any listed species or result in the destruction or adverse modification of habitat of such species which has been designated as critical ("critical habitat"). Although Federal agency authority and responsibility under section 7 have remained virtually intact from the 1973 Act, the Amendments made significant procedural changes in the section 7 consultation procedures.

The 1978 Amendments formalized the process for the issuance of the Secretary's opinion ("biological opinions"), and required that the opinion include "reasonable and prudent alternatives" in cases where the proposed Federal action, in the opinion of the Secretary, would jeopardize the continued existence of a listed species or result in the destruction or adverse modification of its critical habitat. The 1978 Amendments also added section 7(c), requiring the preparation of biological assessments in appropriate instances. section 7(d) of the Act, also added by the 1978 Amendments, prohibits a Federal agency or any involved permit or license applicant, after initiation of consultation, from making an irreversible or irretrievable commitment of resources which would foreclose the adoption of any reasonable and prudent alternatives.

Perhaps the most significant part of the 1978 Amendments was the creation of the Endangered Species Committee, which is authorized to grant exemptions from the requirements of section 7(a)(2) in appropriate cases. Regulations governing the submission of exemption applications and consideration of such applications by the Endangered Species Committee are presently codified at 50 CFR Parts 450–453. Although this final rule on consultation procedures does not deal directly with exemptions, good faith adherence to the consultation requirements of section 7 is a statutory prerequisite for entry into the exemption process.

The 1979 Amendments slightly altered the Federal agency's substantive obligation under section 7(a)(2) from insuring that its action "does not jeopardize" listed species or adversely modify the critical habitat of such species to insuring that its action "is not likely to jeopardize" such species or critical habitat. Congress expressly provided that the consultation and resultant biological opinion be based upon the "best scientific and commercial data available." These changes made the consultation process more flexible and established a reasonable information standard to be followed by the NMFS and FWS (the "Service") and other Federal agencies. The 1979 Amendments added a requirement that all Federal agencies confer with the Secretary on all actions that are likely to jeopardize the continued existence of proposed species or result in the destruction or adverse modification of proposed critical habitat.

The 1982 Amendments also established several new processes under section 7. First, a new subsection 7(b)(4) allows for the issuance of an "incidental take statement" along with a biological opinion. This "incidental take statement" operates to exempt the Federal agency and any permit or license applicant involved from the section 9 "taking" prohibitions under the Act *if* the subsequent implementation of the action is consistent with the terms and conditions of the incidental take statement.

Second, the 1982 Amendments provide an opportunity for permit or license applicant involvement in all

phases of the consultation procedures. A prospective permit or license applicant may request Federal agencies to initiate consultation in advance of filing for any needed license or permit, *if* they have reason to believe that their proposed actions may affect listed species or critical habitat. This new provision, under section 7(a)(3), for "early consultation" allows a prospective applicant the opportunity to discover, and attempt to resolve, potential endangered or threatened species conflicts early in the planning stage of the proposed action—a time at which alterations in project plans could involve much less expense and delay.

Further involvement of the applicant in the consultation procedures is provided by the requirement that the applicant be involved in time extensions. Congress amended section 7(c) to require the Federal agency to give written notice to the applicant explaining why any extension of the biological assessment deadline is needed. If formal consultation under section 7(a)(2) is extended by the Service and the Federal agency for up to 60 days, the Service must provide the applicant with a written explanation of the reasons for extension. Any extension past 60 days must be approved by the applicant. Clearly, the permit or license applicant plays an active role in the consultation process. The final rule recognizes this increased role of the applicant while retaining the requirement that formal communications flow between the Federal agency and the Service during the consultation process.

In order to implement these Amendments to section 7 and to otherwise improve the interagency cooperation process, the Service published a proposed rule on June 29, 1983 (48 FR 29990–30004). Although the Service originally specified a 60-day comment period for these revised section 7 regulations, the comment period was extended until September 30, 1983. The Service received approximately 70 comments from other Federal agencies, State governmental agencies, private organizations, and other individuals and entities on the proposed rule.

After careful consideration of these comments, the Service has modified the regulations to clarify the consultation process and to improve the overall organization of the regulations. These technical changes are more fully explained in the section-by-section analysis below and were made to accommodate concerns raised in the public comments.

General Comments

The majority of the comments received on the proposed rule focused on particular regulatory provisions or concepts. These specific comments are discussed in the section-by-section analysis. However, several commenters expressed general concerns with the proposed rule or addressed matters that went beyond the scope of the proposal.

These general comments ranged from praise for the comprehensiveness of the proposal to criticism for the proposal's alleged failure to require the level of analysis and protection mandated by the Act. The Service believes that this final rule properly and accurately implements the Amendments to the Act and affords the protection mandated by section 7.

The House of Representatives Committee on Merchant Marine and Fisheries ("House Committee"), which oversees the implementation of the Act, submitted comments on the proposed rule. The Committee commended the Service in its efforts to translate complex legislation into agency policy and noted specific areas that it believed did not conform to the legislative intent. These matters have been clarified in the final rule.

One commenter was concerned that the proposed rule confused the informal (nonmandatory) consultation components with the formal (required) components of the consultation process. To clarify this matter, the Service has distinguished optional procedures from required procedures in the final rule. For example, the conference procedures (§402.10) are required for Federal actions that are likely to jeopardize proposed species or proposed critical habitat and the formal consultation procedures (§402.14) are required for actions that may affect listed species or critical habitat. Additionally, biological assessments (§402.12) are required for "major construction activities." Early consultation (§ 402.11) and informal consultation (§402.13) are optional procedures and are clearly designated as such in the final rule.

Concerned about increased paperwork burdens and potential time commitments resulting from the proposal, one commenter complained that the proposed rule is burdensome, unnecessary, and unacceptable. The commenter noted that additional protection for listed species or their habitat would not result from these alleged increases in administrative burdens, and it urged that currently used processes be maintained. The Service emphasizes that the proposal was not intended to increase in any way the paperwork burden of Federal agencies or any other participant in the consultation process. Moreover, the purpose of the proposal was to implement the Amendments to the Act in such a way as to streamline the consultation process while maintaining the protections afforded species under section 7. The concern of the commenter has been addressed to the extent possible by the Service's effort to clarify the consultation process in this final rule. Because section 7 imposes certain requirements on Federal agencies, any burdens recognized in this final rule are a creature of statutory law as implemented by these regulations.

Two commenters asserted that the Act protects habitat only when it is designated as the critical habitat of a listed species and, therefore, the Service must identify areas of critical habitat for all listed species to assure adequate protection. It is true that the Service has not designated critical habitat for all listed species. The Service has consistently taken the position that it is not prudent to designate critical habitat for a species if to do so would increase the risk that the species might be taken or would otherwise not benefit the species. *See* 50 CFR 424.12(a). However, the commenters ignore the fact that section 7 protections attach to both designated critical habitat and to each individual of a listed species within the jurisdiction of the United States or on the high seas. An action could jeopardize the continued existence of a listed species through the destruction or adverse modification of its habitat, regardless of whether that habitat has been designated as "critical habitat." Thus, the failure of the Service to designate critical habitat for a given species does not automatically mean that its habitat is without protection.

Two States commented that Federal agencies charged with implementing the Act should recognize and cooperate with the States in resolving water resource issues within the context of section 7. Consistent with the Department's "good neighbor" policy, one commenter encouraged the Service to actively include affected States in any consultation process. The Service intends to cooperate with all State and local agencies to resolve water resource issues consistent with the requirements of the Act. The Service stands ready to receive any and all comments, data, or other input from any affected States that are interested in a particular section 7 consultation. However, consultation takes place between the Service, the Federal agency and, where applicable, a Federal permit or license applicant.

Several commenters stated that the proposal goes beyond the scope of the Act, thereby placing unjustifiable burdens on applicants and Federal agencies. They claimed that the rules would usurp Federal agency authority. One commenter questioned the ultimate authority of the Service to issue binding procedural regulations under section 7. In no way does the Service intend to use the consultation procedures of section 7 to establish substantive policy for Federal agencies. The Service performs strictly an advisory function under section 7 by consulting with other Federal agencies to identify and help resolve conflicts between listed species and their critical habitat and proposed actions. As part of its role, the Service issues biological opinions to assist the Federal agencies in conforming their proposed actions to the requirements of section 7. However, the Federal agency makes the ultimate decision as to whether its proposed action will satisfy the requirements of section 7(a)(2). The Service recognizes that the Federal agency has the primary responsibility for implementing section 7's substantive command, and the final rule does not usurp that function. The Service is satisfied that the final rule is within the scope of the authority provided in the Act.

Moreover, the Service is responsible for interpreting section 7 and for establishing a consultation process that is both uniform and consistent with statutory requirements. This issue was addressed in the preamble to the 1978 rule:

> The FWS and NMFS are authorized under the Act to issue such regulations as they deem appropriate for the conservation of listed species. The two Services believe that these procedural regulations promote the conservation of listed species by implementing a uniform general framework as the starting point for consultation. Once the mandatory consultation has taken place, however, the ultimate responsibility for determining agency action in light of section 7 still rests with the particular Federal agency that was engaged in consultation. In this fashion, a standardized consultation process is established which preserves ultimate agency administrative control over its activities or programs.

43 FR 870, 871 (Jan. 4, 1978). These procedural regulations do not dictate results but prescribe a process by which the Service will consult in keeping with the Act.

Several commenters stated that Congress did not intend that the Service interpret or implement section 7, and believed that the Service should recast the regulations as "nonbinding guidelines" that would govern only the Service's role in consultation. The Service notes that Congress reviewed with approval the section 7 regulations issued on January 4, 1978, when deliberating over the 1978 Amendments to the Act. *See* H.R. Conf. Rep. No. 1804, 95th Cong., 2d Sess. 18 (1978). Also, the Service was urged by the House Committee, through its comments on the proposed rule, to press forward with the issuance of this final rule. The Service is satisfied that it has ample authority and legislative mandate to issue this rule, and believes that uniform consultation standards and procedures are necessary to meet its obligations under section 7. However, the Service is aware that some Federal programs may require a modified consultation process, and therefore the Service has provided for the issuance of counterpart regulations under § 402.04.

Several general comments were received regarding programmatic adjustments and coordination. One commenter suggested that the Service maintain cumulative summaries of consultation activities in the Washington Office. The Service maintains copies of all biological opinions and monitors the issuance of biological opinions in an effort to ensure consistency and accuracy of findings. The Service submits that current review mechanisms are adequate and that, although the maintenance of cumulative consultation summaries might be useful, the increased costs are not justified.

Another commenter urged increased public participation in the consultation process, including: (1) Public notice of each request for consultation; (2) public notice of the agenda for each consultation; (3) public notice of consultation results; (4) public comment periods; and, (5) prescribed rights to appeal by the public. Nothing in section 7 authorizes or requires the Service to provide for public involvement (other than that of the applicant) in the "interagency" consultation process. Moreover, due to the statutory time constraints imposed on the consultation procedures, it would not be practicable to implement such detailed public participation measures. Public participation may be provided within the Federal agency's decisionmaking process. However, that is a function of the agency's regulations or substantive legislation and not an issue to be raised in the context of consultation.

Finally, several questions were raised as to what rules will apply to pending consultations once the final rule becomes effective. The Service does not anticipate any dramatic change in procedure or additional burdens on Federal agencies because the statutory changes to section 7 have been in effect throughout the development of the final rule. When this rule becomes effective, all pending and future consultations must comply with the requirements of these regulations. The Service will cooperate with the Federal agencies and any applicants to ensure that there are no undue delays in ongoing consultations.

Section-by-Section Analysis

The following portion of the preamble explains the final rule, covering the substantive issues of each section, noteworthy modifications from the proposed rule, significant changes from the 1978 rule, and responses to public comments. To assist the reader, Table 1 presents a citation to each subsection of the proposed rule with appropriate cross-references to the location of that provision in the final rule and in the 1978 rule.

TABLE 1.—CROSS-REFERENCE OF SECTION 7 REGULATORY PROVISIONS: PROPOSAL—FINAL—1978 RULE

Proposal	Final	1978 Rule
§ 402.01(a)–(e)	§ 402.01(a)–(b)	§ 402.01
§ 402.02 Definitions	§ 402.02 Definitions	§ 402.02 Definitions.
(none)	—"Act"	(none)
—"Action"	—"Action"	—"Activities or programs"
—"Action area"	—"Action area"	(none)
—"Adversely affect"	(none)	(none)
—"Applicant"	—"Applicant"	(none)
—"Biological assessment"	—"Biological assessment" and "Major construction activity"	(none)
—"Biological opinion"	—"Biological opinion"	(none)
—"Conference"	—"Conference"	(none)
—"Conservation"	(none)	(none)
—"Conservation recommendations"	—"Conservation recommendations"	(none)
—"Consultation process"	(none)	(none)
—"Critical habitat"	—"Critical habitat"	—"Critical habitat"; § 402.05

TABLE 1.—CROSS-REFERENCE OF SECTION 7 REGULATORY PROVISIONS: PROPOSAL—FINAL—1978 RULE—Continued

Proposal	Final	1978 Rule
—"Cumulative effects"	—"Cumulative effects"	(none)
—"Designated non-Federal representative"	—"Designated non-Federal representative"; § 402.08	(none)
—"Destruction or adverse modification"	—"Destruction or adverse modification"	—"Destruction or adverse modification"
—"Director"	—"Director"	—"Director or Regional Director"
—"Early consultation"	—"Early consultation"	(none)
—"Effects of the action"	—"Effects of the action"	(none)
—"Federal agency"	(none)	—"Federal agency"
—"Formal consultation"	—"Formal consultation"	(none)
—"Further discussion"	(none)	(none)
—"Incidental take"	—"Incidental take"	(none)
—"Informal consultation"	—"Informal consultation"	(none)
—"Jeopardize the continued existence of"	—"Jeopardize the continued existence of"	—"Jeopardize the continued existence of"
—"Listed species"	—"Listed species"	—"Listed species"
—"Preliminary biological opinion"	—"Preliminary biological opinion"	(none)
—"Proposed critical habitat"	—"Proposed critical habitat"	(none)
—"Proposed species"	—"Proposed species"	(none)
—"Reasonable and prudent alternatives"	—"Reasonable and prudent alternatives"	(none)
(none)	—"Reasonable and prudent measures"	(none)
—"Recovery"	—"Recovery"	—"Recovery"
—"Service"	—"Service"	(none)
§ 402.03	§ 402.03	§ 402.03
§ 402.04	§ 402.04	§ 402.04(i)
§ 402.05	§ 402.05(a)–(b)	(none)
§ 402.10(a)	§ 402.06(a)	§ 402.04(b)(1)
———(b)	§ 402.06(a)	(none)
———(c)	(none)	(none)
———(d)	§ 402.07	§ 402.04(b)(2)
§ 402.11	§ 402.09	§ 402.04(a)(3)
§ 402.12(a)	§ 402.13(a)–(b)	§ 402.04(a)
———(b)	§ 402.12(a)–(k)	§ 402.04(c), (d)
§ 402.13(a)–(c)	§ 402.10(a)–(e)	(none)
§ 402.14	§ 402.11	(none)
§ 402.15(a)	§ 402.14(a)	§ 402.04(a)
———(b)	§§ 402.11(f), 402.14(b)(2)	(none)
———(c)	§§ 402.13(a), 402.14(b)	§ 402.04(a)
———(d)	§ 402.14(c)–(d)	———(a), (c), (d)
———(e)	———(e)	———(e), (f)
———(f)	———(g)	———(e)
———(g)	———(h)	———(e)
———(h)	———(h)–(j)	———(e)
———(i)(1)	§ 402.13(a)	(none)
———(i)(2)–(4)	§§ 402.14(f), 402.15(b)	(none)
———(j)(1)	———(f)	§ 402.04(f)
———(j)(2)	———(k)	(none)
———(k)	———(a)	§ 402.04(a)
§ 402.16	(none)	(none)
§ 402.17(a)	§ 402.15(a)	§ 402.04(g)
———(b)	§ 402.15(c)	(none)
———(c)	§ 402.06(b)	§ 402.04(g)
§ 402.18	§ 402.16	§ 402.04(h)
§ 402.19	§ 402.14(i)	(none)

Subpart A—General

Section 402.01 Scope.

This section describes the purpose and scope of these regulations. Section 402.01 of the proposed rule contained an introductory paragraph and five subsections that were largely repetitive of other sections of the rule. These repetitive passages have been deleted from the final rule, and minor editorial corrections have been made.

Several commenters noted that, although § 402.01 acknowledges the language of section 7(a)(1) of the Act, no guidance is provided to enable Federal agencies to meet their conservation responsibilities under the Act. Claiming that the rules are silent as to Federal agency management programs required for the recovery of listed species, one commenter advised the Service to add a statement in the rule that would insure that Federal agencies address recovery as well as detrimental effects through consultation. According to another commenter, this statement may include a request that Federal agencies issue policies and procedures to implement their authority under section 7(a)(1).

The Service notes that it is beyond the scope of these regulations to address how other Federal agencies should implement and exercise their authority to carry out conservation programs for listed species under section 7(a)(1). However, the Service stands ready to assist any Federal agency in developing and carrying out conservation programs. The Service cautions that all Federal actions including "conservation programs" are subject to the consultation requirements of section 7(a)(2) if they "may affect" listed species or their critical habitats. If the Service agrees, through informal consultation, that the action is not likely to adversely affect the species, then formal consultation is not required [see § 402.13(a)–(b)]. Each Federal agency has the responsibility to implement its authority under section 7(a)(1). Further, any conservation program must comply with applicable permit requirements to the extent that such actions involve the taking of listed species. "Take," as defined in the Act, means to harass, harm, pursue, hunt, shoot, wound, kill, trap, capture, or collect, or to attempt to engage in any such conduct.

The 1978 rule extended the scope of section 7 beyond the territorial limits of the United States to the high seas and foreign countries. The proposed rule cut back the scope of section 7 to the United States, its territorial sea, and the outer continental shelf, because of the apparent domestic orientation of the consultation and exemption processes resulting from the Amendments, and because of the potential for interference with the sovereignty of foreign nations.

Several commenters asserted that the rules should continue to have extraterritorial effect. The scope of these regulations has been enlarged to cover Federal actions on the high seas but has not been expanded to include foreign countries. The Service finds that, because it already has jurisdiction under section 9(a)(1)(C) of the Act to regulate the taking of a listed fish or wildlife species on the high seas by all persons subject to the jurisdiction of the United States, concomitant jurisdiction under section 7 is implicit from Congressional concern that compliance with a section 7 incidental take statement not result in a taking violation under section 9(a)(1)(C), as provided in section 7(o)(2).

Although consultations on Federal actions in foreign countries will not be conducted under this rule, the Service maintains its strong commitment to the preservation of species and habitat worldwide. The Service will continue to list species which are found outside of United States jurisdiction when they are determined to be endangered or threatened.

Furthermore, Congress, in the International Environment Protection Act of 1983, 22 U.S.C. 2151q, made a finding that "the extinction of animal and plant species is an irreparable loss with potentially serious environmental and economic consequences for developing and developed countries alike." Accordingly, it places the preservation of species "through limitations on the pollution of natural ecosystems, and through the protection of wildlife habitats" as an "important objective of the United States development assistance." In furtherance of this policy, an Interagency Task Force was established to develop a national strategy for the protection and conservation of biological diversity in developing countries. The task force did not specifically recommend that international assistance activities be subject to consultation requirements, but did cite section 7(a)(2) in recommending that Federal agencies "should continue to adopt policies withholding support for certain types of projects that degrade or destroy fragile or protected lands." Until enacted by Congress, however, the recommendations of the task force will not be implemented in these regulations for the reasons stated above.

One commenter urged the Service to change the standard for initiating a section 7(a)(4) conference from "likely to jeopardize" to "would adversely affect." The regulation tracks the statute, and the Service lacks the authority to make the requested change. The same commenter noted that the section 7(d) sentence referred to a "*would* avoid jeopardizing" standard. (Emphasis theirs.) Again, the Service adopts the regulation as in keeping with the statutory standard.

Another commenter stated that biological opinions need only be required after formal consultation under section 7(a)(2) of the Act and that this should be clarified in the rule. The Service disagrees because the statute requires that a "written statement" containing the Secretary's opinion be issued after the conclusion of both early and formal consultation. The rule has been amended slightly to clarify this requirement.

The commenter also requested that the sentence in proposed § 402.01(d) dealing with section 7(d) be amended by adding "measures" after the phrase "reasonable and prudent alternative[s]" to bring the regulation in line with the statute. The Service declines to make this change because it would tend to confuse "reasonable and prudent alternatives" that are included in jeopardy biological opinions with "reasonable and prudent measures" that are included in an incidental take statement under section 7(b)(4) of the Act. The proposed language describing the section 7(d) prohibition accurately implements the Act and is adopted in this final rule.

Section 402.02 Definitions.

This section sets out definitions of terms that are used throughout these regulations. As noted in Table 1, many definitions have been added to those included in the 1978 rule. Only comments which specifically addressed the definitions used in these regulations are discussed in this section. These terms are further discussed as they pertain to the consultation procedures in the appropriate, subsequent sections.

A definition of "Act" has been added to the final rule. It refers to the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*).

The definition of "action" parallels the former definition of "activities or programs," a term that predated the Amendments. Several changes have been made in the definition of "action" to accommodate public comments: First, the definition is expanded to cover activities occurring on the high seas. (*See* § 402.01 segment of the Preamble.) Second, the phrase "actions that are intended to conserve listed species or their habitat" was restored from the 1978 rule because of the decision to require Service review of all Federal actions that may affect listed species or their critical habitat. (*See* § 402.14 segment of the Preamble.) The Service declines to define further or to delete the reference to actions that "indirectly cause modifications to the land, water, or air" in this definition. The concept of indirect effects is adequately addressed in the discussion of "cumulative effects" and "effects of the action."

The definition of "action area" is adopted from the proposed rule. Several commenters criticized the vagueness or apparent expansiveness caused by the reference to indirect effects in this definition. The definitions of "cumulative effects" and "effects of the action" further clarify the scope of "indirect effects."

The Service is not able to define specific spatial and temporal limits for the concept of indirect effects that would satisfy every conceivable situation, and believes that sufficient understanding of the term exists so that confusion will not occur. "Action area" is not limited to the immediate area involved in a Federal action.

"Applicant," an abbreviated term including all permit or license applicants, was defined in the proposed rule because of the increased role of permit or license applicants in the consultation process. Although the Act defines "permit or license applicant" in section 3(12), the Act's definition is of limited use in the consultation context because it focuses on the exemption process under section 7. The definition in the proposed rule broadly defines "applicant" as "any person who requires formal approval or authorization from a Federal agency as a prerequisite to conduct the action." Thus, applicants would include those seeking permits, licenses, leases, letters of authorization, and any other form of authorization or approval issued by a Federal agency as a prerequisite for carrying out the action.

One commenter suggested that the definition of applicant be amended to allow prospective permit applicants to participate in section 7 consultations involving the promulgation of regulations governing permit issuance. The applicant (or prospective applicant) is involved in the consultation process as a result of a specific permit or license application. The applicant may provide input regarding its concerns in the Federal agency's rulemaking process through the Administrative Procedure Act, 5 U.S.C. 551 *et seq.* Further, a prospective applicant could request early consultation through the Federal agency under § 402.11 of this rule on its prospective application during the course of agency rulemaking, if it desires early notice of potential conflicts and if it meets the requirements of these

regulations. This would involve interaction with the Service, but it would be limited in scope to the prospective application for the permit at issue, not a general consultation on the pending rulemaking. In response to another comment, the Service takes the position that it will not expand "applicant" to include those seeking funding from Federal agencies, unless the request for funding is coupled with a requirement that the person obtain Federal approval or authorization as a prerequisite for carrying out the action for which funding is sought. Finally, one commenter asked that the scope of the definition be expanded to include corporations, Federal agencies, and all other legal entities. The Service believes that the use of the word "person" in the definition satisfies the commenter's concern because of the broad definition of that term in section 3(13) of the Act. To clarify this point, the Service added a reference to the Act's definition of "person" in the definition of "applicant" in the final rule.

The definition of "biological assessment" in the final rule, derived from §§ 402.02 and 402.12(b)(4)(ii) of the proposed rule, clarifies that the assessment must include an evaluation of potential impacts. One commenter criticized the "vagueness" of the definition of "biological assessment" in the proposed rule, stating that it was unclear as to how a Federal agency would determine which species or critical habitat may be in the action area and how the agency would evaluate potential effects. The Service believes that this definition is adequate and that the process-oriented format in § 402.12 of the regulations adequately explains the scope and procedure of the biological assessment requirement.

The proposed definition of "biological opinion" has been adopted in these final rules. A biological opinion is the document that states the Service's opinion as to whether or not the Federal action is likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat. One commenter suggested a third possible conclusion for biological opinions: "insufficient information to issue an opinion." The commenter argued that such a conclusion would eliminate the risk that the Service takes when issuing an opinion based on arguably inadequate data. The Service declines to add this third option. The legislative history of the Act is clear in requiring the Service to make a decision on the issue of likely jeopardy at the conclusion of formal consultation. The Service will not sidestep this obligation, but instead will conclude either "jeopardy" or "no jeopardy" based on the best available data.

The definition of "conference" has been adopted as proposed. One commenter suggested that the conference not include recommendations to minimize or avoid adverse effects since they are not required by section 7(a)(4) of the Act. The commenter believed that such recommendations might result in legal action if not adopted. The Service, however, believes it has the responsibility not only to identify impacts but also to identify measures that would reduce those impacts.

The definition of "conservation" contained in the proposed rule was derived from the Act's definition in section 3(3). One commenter, characterizing the Service's interpretation of "conservation" as opposing the purposes of the Act and potentially encouraging the "further decline" of listed species, urged the Service to adopt the strict language of the statutory definition. The Service's definition in the proposed rule in no way discouraged recovery. In fact, the proposed definition tracked the statute except for its interpretation of "the point at which the measures provided pursuant to this Act are no longer necessary" as being equivalent to "the point at which [the species] may be removed from the Lists . . . ." The basic goal of the Act is to recover listed species through conservation measures. Bringing a species to the point at which the Act's protective measures are no longer necessary is the same as bringing the species to the point at which delisting is appropriate. However, to avoid any misunderstanding, the Service has deleted the definition from the final rule and will rely solely on the definition contained in section 3(3) of the Act. The Service declines specifically to include habitat modification (improvement or restoration), "off-site mitigation," captive propagation, and species reintroduction in the list of conservation methods and procedures, as suggested by certain commenters. Such activities are already adequately provided for in the Act's definition.

The term "conservation recommendations" was introduced in the proposed rule and explains the Service's role in helping agencies meet their section 7(a)(1) responsibilities. Several commenters feared that the Service would employ conservation recommendations to require Federal agencies to reformulate their actions that had received "no jeopardy" biological opinions. This is not the purpose of conservation recommendations. They are nonbinding suggestions that a Federal agency may elect to implement in its proposed action. These recommendations should be consistent with the general scope, magnitude, and duration of a Federal action that is not likely to jeopardize a listed species or destroy or adversely modify its critical habitat. The Service, in answering the concerns noted above, is satisfied that it has clarified its position and that the regulatory definition should not be deleted. The Service has chosen to retain this definition with limited, technical changes because it believes that the opportunity to provide conservation recommendations, including minor design modifications, may minimize possible adverse effects and may avoid future section 7 conflicts for subsequent Federal actions in the same action area.

One commenter confused "conservation recommendations" with "reasonable and prudent alternatives" and believed that recommendations to *reduce* adverse impacts would violate section 7(a)(2), absent the granting of an exemption. The obligation of Federal agencies under section 7(a)(2) is to insure that the actions they authorize, fund, or carry out are not likely to *jeopardize* listed species or destroy or adversely modify their critical habitat. A showing of "adverse effect" does not necessarily violate section 7(a)(2), because the jeopardy standard is the ultimate barrier through which Federal agencies may not pass in conducting their actions. "Reasonable and prudent alternatives" represent avenues of fulfilling the action without violating the jeopardy standard. "Conservation recommendations" involve voluntary measures that the Federal agency has the discretion to undertake to avoid or reduce adverse effects of a proposed action that otherwise complies with the provisions of section 7(a)(2).

The definition of "consultation process" has been deleted from the final rule because it tended to confuse the statutory requirements and optional processes and because it added little to the public's understanding of the process. The definition in the proposed rule could have led persons to believe that early consultation and informal consultation are required, sequential steps of the overall consultation process. As discussed above, the only required components of the consultation process are a "conference" for proposed species, a "formal consultation" for listed species, and a biological assessment for "major construction activities."

The "critical habitat" definition contained in the proposed rule only referred to those sections of 50 CFR Parts 17 and 226 that contain the lists of those areas so designated. The mechanics of the designation process are more properly considered under the section 4 regulations (50 CFR Part 424). For purposes of determining whether any of their actions is likely to destroy or adversely modify critical habitat, Federal agencies involved in section 7 consultations need only be aware of those areas that have been designated by the Service as critical habitat. Two commenters requested that a definition of critical habitat be included in the final rule. The Service notes that the requested definition is contained in the Act and need not be repeated here.

"Cumulative effects" and "effects of the action" are defined in § 402.02 of the final regulations. Under § 402.14(g) (3) and (4) of the final rule, the Service will consider both the "effects of the action" subject to consultation and "cumulative effects" of other activities in determining whether the action is likely to jeopardize the continued existence of a listed species or result in the destruction or adverse modification of critical habitat.

In determining the "effects of the action," the Director first will evaluate the status of the species or critical habitat at issue. This will involve consideration of the present environment in which the species or critical habitat exists, as well as the environment that will exist when the action is completed, in terms of the totality of factors affecting the species or critical habitat. The evaluation will serve as the baseline for determining the effects of the action on the species or critical habitat. The specific factors that form the environmental baseline are given in the definition of "effects of the action," as requested by some commenters.

"Effects of the action" include the direct and indirect effects of the action that is subject to consultation.

"Indirect effects" are those that are caused by the action and are later in time but are still reasonably certain to occur. They include the effects on listed species or critical habitat of future activities that are induced by the action subject to consultation and that occur after that action is completed. In *National Wildlife Federation* v. *Coleman*, 529 F.2d 359 (5th Cir. 1976), the Court of Appeals for the Fifth Circuit found that "indirect effects" which can be expected to result must be considered under section 7 of the Act. In that case, the court enjoined completion of a highway because the Department of Transportation failed to consider the effects to the endangered sandhill crane from future private development that would result from construction of the highway. The Service will consider the effects to listed species from such future activities that are reasonably certain to occur under the analysis of "indirect effects." The Service's approach will be consistent with *National Wildlife Federation* v. *Coleman*, and the Service declines to narrow the scope of its review (as requested by one commenter) in light of existing case law.

Effects of the action also include direct and indirect effects of actions that are interrelated or interdependent with the proposal under consideration. Interrelated actions are those that are part of a larger action and depend on the larger action for their justification; interdependent actions are those that have no significant independent utility apart from the action that is under consideration. As noted by one commenter, the "but for" test should be used to assess whether an activity is interrelated with or interdependent to the proposed action.

One commenter urged the Service to exclude Federal actions that have completed consultation from the environmental baseline unless it can be shown that the actions are reasonably certain to occur. The Service declines to adopt this suggestion. In issuing its biological opinion on an action, the Service's finding under section 7(a)(2) entails an assessment of the degree of impact that action will have on a listed species. Once evaluated, that degree of impact is factored into all future section 7 consultations conducted in the area. These impacts will continue to be considered as part of the environmental baseline unless the Service receives notice from the Federal agency that the proposed action will not be implemented or unless the biological opinion on the proposed action is no longer valid because reinitiation of consultation is required.

In response to one comment, the Service notes that Federal actions that have proceeded through early consultation and that have received "no jeopardy" preliminary biological opinions should be factored into the environmental baseline. These actions, to be eligible for early consultation, had to be nonspeculative, feasible actions, and, because the preliminary biological opinion can later be confirmed as a final biological opinion, this initial review and conclusion by the Service must be considered in other section 7 consultations.

The term "cumulative effects" means those effects on the species caused by other projects and activities unrelated to the action under consultation that the Service will consider in formulating its biological opinion on the subject action. One commenter opposed the proposed definition of cumulative effects by arguing that the Act does not require an analysis of cumulative effects in a section 7 consultation. Citing section 7(c), the commenter noted that biological assessments may be limited to an examination of effects of "such action" on listed species. The commenter urged the Service to strike cumulative effects analysis from this rule because few Federal agencies have the capability to recognize or assess cumulative effects of State or private actions contemporaneously with conducting section 7 consultation. According to the commenter, the Service, as the expert on current status of listed species, should keep watch on these State and private activities that come on line in a particular action area. The Service responds that a Federal agency, when evaluating the environmental impacts of a proposed action, must comply with NEPA. Since this compliance includes an analysis of cumulative effects, the Service believes that it is the Federal agency's responsibility to develop this information. The cumulative effects analysis conducted in compliance with the broad definition under NEPA may be submitted to the Service by the Federal agency when initiating formal consultation. The Service can use this analysis and apply its narrower definition of cumulative effects when analyzing whether a proposed action, along with cumulative effects, violates section 7(a)(2) of the Act.

Other commenters, while not opposing the applicability of cumulative effects analysis to section 7 consultations, believed that the proposed scope of "cumulative effects" and "effects of the action" were too narrow. These commenters generally suggested that cumulative effects should include the effects of all reasonably foreseeable future Federal, State, and private actions. They stated that this scope would be more in line with that mandated under NEPA and argued that any lesser review could detrimentally affect endangered species. The commenters adamantly opposed any limitation on the foresight employed by the Service or Federal agencies that they believed would result from the proposal's construction of cumulative effects.

Section 7 consultation will analyze whether the "effects of the action" on listed species, plus any additional,

cumulative effects of State and private actions which are reasonably certain to occur in the action area, are likely to jeopardize the continued existence of that species. Based on this analysis, the Federal agency determines whether it can proceed without exceeding the jeopardy standard. If the jeopardy standard is exceeded, the proposed Federal action cannot proceed without an exemption. This is a substantive prohibition that applies to the Federal action involved in the consultation. In contrast, NEPA is procedural in nature, rather than substantive, which would warrant a more expanded review of cumulative effects. Otherwise, in a particular situation, the jeopardy prohibition could operate to block "nonjeopardy" actions because future, speculative effects occurring after the Federal action is over might, on a cumulative basis, jeopardize a listed species. Congress did not intend that Federal actions be precluded by such speculative actions.

Future Federal actions proposed for the same area would have to be separately evaluated under section 7 and could not occur unless they were able, in their own right, to avoid jeopardizing the continued existence of the affected species or destroying or adversely modifying critical habitat. Since all future Federal actions will at some point be subject to the section 7 consultation process pursuant to these regulations, their effects on a particular species will be considered at that time and will not be included in the cumulative effects analysis. However, those future State or private actions (*i.e.*, no Federal agency involvement) that are "reasonably certain to occur" must be factored into section 7(a)(2) evaluations. The Service agrees that cumulative effects that are reasonably certain to occur will be considered in determining the likelihood of jeopardy. The final rule is amended accordingly, to clarify the duty to consider cumulative effects.

One commenter thought that the "reasonably certain to occur" standard was far too narrow and that it should be amended to cover actions where proposals have been made, and implementation schedules have been established. This suggestion would open the door for speculative actions to be factored into the "cumulative effects" analysis, adding needless complexity into the consultation process and threatening potential Federal actions which pose minimal adverse impacts of their own with possible "jeopardy" opinions due to speculative, State or private projects that may never be implemented. For State and private actions to be considered in the cumulative effects analysis, there must exist more than a mere possibility that the action may proceed. On the other hand, "reasonably certain to occur" does not mean that there is a guarantee that an action will occur. The Federal agency and the Service will consider the cumulative effects of those actions that are likely to occur, bearing in mind the economic, administrative, or legal hurdles which remain to be cleared. The Service declines to alter its "cumulative effects" definition to include State or private actions that are not likely to occur.

One issue was raised concerning the application of cumulative effects analysis to water projects. A commenter contended that State and private projects that possess senior water rights under State water law and that can "reasonably be expected to occur" concurrently with the Federal action should be considered as cumulative effects. The Service notes that any State or private project (*i.e.*, no Federal agency involvement) that is reasonably certain to occur must be considered during the analysis of cumulative effects. Further, the Service believes that Federal actions, whether authorized, funded, or carried out by Federal agencies, that possess senior water rights should be considered while analyzing the effects of the action. In order to determine the effects of the action when a water project is the subject of consultation in a State which follows the prior appropriation doctrine, the project's operation plan should indicate the priority of the project's water rights under State law and account for the future effects of senior conditional water rights.

On a related matter, the Associate Solicitor's opinion on the scope of cumulative effects cited in the proposed rule provided, in part, that only those effects of other projects that are reasonably certain to occur *prior* to the completion of the Federal action subject to consultation under section 7(a)(2) should be considered during formal consultation. This statement has been interpreted by some to exclude from cumulative effects analysis those future State and private actions that, while "reasonably certain to occur," would not be completed *before* the completion of the Federal action subject to consultation. Such an interpretation places undue emphasis on the use of the word "prior" while ignoring the central concept that the Associate Solicitor's opinion intended to project: that a proposed State or private activity be "reasonably certain to occur" in order to be taken into account during cumulative impact analyses. If such a State or private project satisfies the "reasonable certainty" test, then it should be considered in the cumulative impact analysis, even if it would go on line sometime after completion of the federally authorized, funded, or carried out project which was the subject of consultation. To the extent that the Associate Solicitor's opinion created the opposite impression, the Service takes this opportunity to clarify this point.

Moreover, as suggested by some commenters, and for the reasons outlined above, the Service has deleted its reference to the Interior Department position on "cumulative effects" in 88 I.D. 903 (1981) in the definition section. The Service disagrees with the commenter who stated that the citation to the legal opinion in the proposed definition denied the public meaningful comment on these regulations. The policy was widely known, and it was explained in the preamble to the proposed rule. The Associate Solicitor's opinion on "cumulative effects" is published in Interior Decisions, a publication available to the general public. Finally, the opinion does not represent a policy change subject to Administrative Procedure Act (APA) informal rulemaking proceedings. It represented Interior's legal interpretation of the scope of "cumulative effects" under section 7, adopted and published in 1981 in keeping with APA requirements. 5 U.S.C. 552(a). Therefore, no reproposal is needed on this issue.

The definition of "designated non-Federal representative" is adopted from the proposal in part. First, in response to a comment, the Service explains that the non-Federal representative may conduct informal consultations (§ 402.13) and/or prepare biological assessments (§ 402.12). However, Federal agencies cannot delegate their role in initiating formal consultation, a conference, or early consultation. The second sentence of the proposed definition has been deleted, but a new § 402.08 has been added to further explain the role of the designated non-Federal representative.

The proposed definitions of "destruction or adverse modification" and "jeopardize the continued existence of" received a lot of attention from commenters. Both definitions contained, as did the 1978 rule, the phrase "survival and recovery." The final rule retains the language of the proposed definitions, except for the changes noted below. Also connected with these terms is the definition of "recovery." The "recovery" of a listed species means that the status

of the species has improved to the point at which it may be removed from the Lists of Endangered and Threatened Wildlife and Plants.

The principal controversy involving the "jeopardy" and "destruction or adverse modification" definitions was that, under the proposed rule, to find that an action is likely to jeopardize a listed species or result in the destruction or adverse modification of critical habitat, the Service must identify detrimental impacts to "both the survival and recovery" of the listed species. The conjunction "and" was used in the 1978 rule's definitions of these phrases, but the word "both" was added by the proposed rule to emphasize that, except in exceptional circumstances, injury to recovery alone would not warrant the issuance of a "jeopardy" biological opinion. The Service adopts these definitions substantially without change from the proposed rule; this does not represent a change in policy, as one commenter charged, because the Service has internally interpreted the "jeopardy" standard as requiring detrimental impacts to the continued existence of a species under a joint survival and recovery concept. Other Federal agencies are assured that the same "jeopardy" standard under which their actions have been evaluated in the past will be continued under this final rule.

Several commenters urged the Service to strike the "and" and insert "or" in the definitions of "jeopardy" and "destruction or adverse modification." They argued that injury to recovery for an already depleted species would require the issuance of a jeopardy opinion. They also remarked that the Service's position disregarded the conservation requirements of the Act, failed to adequately protect critical habitat, operated to weaken or nullify recovery efforts, and otherwise violated the purposes and policies of the Act.

These commenters misconstrued the Service's role in conducting consultations under section 7(a)(2) of the Act. The purpose of consultation is to identify conflicts between proposed Federal actions and the "jeopardy" standard of section 7(a)(2). The "continued existence" of the species is the key to the jeopardy standard, placing an emphasis on injury to a species' "survival." However, significant impairment of recovery efforts or other adverse effects which rise to the level of "jeopardizing" the "continued existence" of a listed species can also be the basis for issuing a "jeopardy" opinion. The Service acknowledges that, in many cases, the extreme threats faced by some listed species will make the difference between injury to "survival" and to "recovery" virtually zero.

One commenter disagreed that actions adversely affecting survival of a species will also always adversely affect its recovery. The commenter did not cite examples where an action that jeopardized "survival" of a species would not jeopardize its "recovery." The Service is not aware of any examples and believes that it would be very difficult to recover a species whose survival had been placed in jeopardy. The very concept of "jeopardy" is that a Federal agency should not authorize, fund, or carry out an action that would injure a listed species' chances for survival to the point that recovery is not attainable. If survival is jeopardized, recovery is also jeopardized. As noted above, though, these concepts are generally considered together in analyzing effects, and it is difficult to draw clear-cut distinctions.

The concept of "survival" is discussed above, but is not defined in the Act or in these regulations. Two commenters felt that "survival" should be defined in the regulations, and one urged the Service to adopt the following specific definition:

> "Survival" for a species means retention of a sufficient number of individuals and/or populations with necessary habitat to insure that the species will keep its integrity in the face of genetic recombination and known environmental fluctuations.

The Service agrees with the criteria set out in the above definition, but declines to adopt a regulatory definition for "survival" because this concept varies widely among listed species. The Service will apply the statutory standard of jeopardy to the continued existence of a species on a case-by-case basis, taking into account the particular needs of and the severity and immediacy of threats posed to a listed species. The Service is not attempting to predetermine the results of any future consultations by announcing these interpretations of the "jeopardy" standard, but instead is emphasizing what "jeopardy" is and how it should be applied in the section 7(a)(2) process.

One commenter urged the Service to go further and forbid any Federal action to proceed, regardless of a "no jeopardy" finding, if the proposed action would adversely affect the recovery of a listed species. Numerous commenters cited sections 2(c)(1), 3(3), and 7(a)(1) of the Act as authority for the Service to ban Federal agency actions that "violate the requirement to conserve endangered species."

The commenters misinterpret the statutory changes which the Amendments have made to section 7, and they misconstrue court decisions which have noted the apparent "heightened" responsibility of the Secretary. The Service will undertake programs for the conservation of listed species and will consult with other Federal agencies attempting to do the same. The Service will not, nor does it have the authority to, mandate how or when other Federal agencies are to implement their responsibilities under section 7(a)(1), nor is the Service authorized to issue a biological opinion under section 7(a)(1) of the Act. Section 7(a)(1) has a limited purpose under the Act: to authorize Federal agencies to factor endangered species conservation into their planning processes, regardless of other statutory directives.

In contrast, section 7(a)(2) contains the mandatory "jeopardy" standard. The prohibitory features of section 7, and the exemption process added by the 1978 Amendments, focus on the provisions of section 7(a)(2). Although there is no express legislative history directly weighing and comparing the relative strengths of section 7(a)(1) with 7(a)(2), there can be no doubt that Congress considered the jeopardy standard of section 7(a)(2) as being the substantive cornerstone of section 7:

> The term "is likely to jeopardize" is used because the *fundamental* obligation of section 7(a) of the act is that Federal agencies insure their actions do not jeopardize the continued existence of an endangered or threatened species.

S. Rep. No. 151, 96th Cong., 1st Sess. 4 (1979) (emphasis added). Congress intended that the "jeopardy" standard be the ultimate barrier past which Federal actions may not proceed, absent the issuance of an exemption. The commenters' argument would require Federal actions to halt if they failed to conserve listed species, a result clearly not intended by Congress. Congress intended that actions that do not violate section 7(a)(2), or actions receiving an exemption from the requirements of that subsection, be allowed to proceed.

Commenters argued that it would be a violation of section 7(a)(1) for the Service to issue a "no jeopardy" biological opinion for a proposed Federal action that would have an adverse effect on the recovery of a listed species. As previously stated, the Service lacks authority to issue biological opinions under that subsection, and the Act does not mandate particular actions to be taken by Federal agencies to implement 7(a)(1). Furthermore, adverse effects not

rising to the level of "jeopardizing the continued existence" of a listed species cannot be the basis for issuing a jeopardy opinion.

The Service disputes two commenters' assertions that "the Service now proposes to allow the 'continued existence' of a listed species to reach a state of likely jeopardy." The Service has followed and will continue to follow the policy of strictly applying the jeopardy standard of section 7(a)(2) in the consultation process. The Service has not and will not relax the statutory standard.

One commenter stated that limiting the definition of "destruction or adverse modification" to critical habitat is illogical. This limitation is mandated by the strict language of section 7(a)(2) and cannot be altered by the Service, although habitat destruction can be the basis for a jeopardy opinion in appropriate cases.

Another commenter requested that examples be given of actions that might indirectly alter critical habitat. The Service responds with the following examples of indirect alteration of critical habitat (which is not intended as an exclusive list): ground water pumping that occurs on land adjacent to the critical habitat area, but nevertheless diminishes essential ground water levels within the critical habitat; air pollution created by an action not occurring directly on the critical habitat area that causes a deterioration of essential air quality levels in the critical habitat; contamination of water supply within the critical habitat caused by release of toxic substances outside of the critical habitat area; etc.

In the definition of "jeopardize the continued existence of," one commenter suggested the word "could" be substituted for "would" in the phrase "would be expected, directly or indirectly, to reduce appreciably the likelihood of . . . the survival and recovery of listed species . . . ." Such a change would be an unwarranted deviation from the language of the 1978 rule in light of subsequent Amendments to the Act. The Service retains the substance of the proposed language, but does delete the phrase "or otherwise adversely affecting the species" because, as several commenters suggested, the phrase is confusing and adds nothing to the definition.

In response to several comments, the Service has modified the definition of "recovery" to make it clear that recovery is not attained until the threats to the species as analyzed under section 4(a)(1) of the Act have been removed. The protective measures provided for listed species under the Act are no longer needed if endangered or threatened status is no longer applicable to a species under section 4(a)(1).

The definition of "Director" has been modified by the addition of the phrase "or his authorized representative" after "the FWS regional director" and "Assistant Administrator for Fisheries" to accommodate present and future delegations of authority to carry out certain consultation responsibilities. Although the Minerals Management Service requested that all Outer Continental Shelf (OCS) section 7 biological opinions issued by the FWS be signed by the Washington Office, the authority to sign such opinions will remain with the regional offices because they have been staffed specifically to conduct all interagency consultations and to sign the resulting biological opinions.

The term "early consultation" was included in the proposed rule pursuant to the provisions of section 7(a)(3). This section authorizes the Service to consult with Federal agencies at the request of prospective applicants, prior to the submission of the permit or license application to that Federal agency. The definition has been modified to reference the appropriate section of the Act.

One commenter requested that, instead of using the term "early consultation," the Service refer to this process as "consultation on behalf of prospective applicants." The commenter was concerned that, by calling this pre-application process "early consultation," the Service would fail to alert Federal agencies and applicants of the need to determine impacts to endangered or threatened species early in the planning stages of all of their actions, regardless of whether the consultation is early, informal, or formal. The Service retains the label "early consultation" due to its convenience, its frequent use in the committee reports on the 1982 Amendments, and its common acceptance within and outside the Service. The Service believes that the language provided in § 402.14(a), advising Federal agencies to review their actions at the earliest possible time, provides adequate safeguards to address the commenters' concerns.

The definition of "Federal agency" has been deleted since it is defined in section 3(7) of the Act. The Service declines to expand the statutory definition to accommodate one commenter's concern. The statutory definition adequately provides notice that all departments, agencies, and instrumentalities of the United States come within the scope of section 7. The Service will not interpret this term further in the final rule.

The definition of "formal consultation" has been modified to specify that it is the consultation required under section 7(a)(2) of the Act. Other minor, technical changes have also been made. The phrase "after it has been determined, through informal consultation with the Service, that its action may adversely affect listed species or critical habitat" has been deleted from the proposed definition because, as recommended by some commenters, informal consultation is strictly an optional process. Although the Federal agency may elect to enter into informal consultation to determine if formal consultation is required, the Federal agency can initiate formal consultation any time that it determines its action may affect listed species or critical habitat.

"Further discussion" was an optional process included in the proposed rule. It provided the Federal agency and any applicant the opportunity to continue consultation after the issuance of a biological opinion in order to discuss with the Service any reasonable and prudent alternatives and any conservation recommendations. Recommendations and alternatives could be refined or developed during these discussions, and consultation would terminate with the Federal agency's written notice of its final decision on the action. Because of concerns expressed by commenters, this provision contained in proposed § 402.16 has been deleted from the final rule.

Although several commenters supported this provision, many opposed further discussion contending that it is unnecessary, that all reviews and discussions should occur prior to the issuance of the biological opinion, that it extends consultation beyond the statutory time limits, and that it lacks statutory authority. Although the process was optional, some commenters believed that there was an implication that the Federal agency or applicant would have a duty to engage in further discussion.

Although further discussion has been deleted, the Service is available to discuss the biological opinion, any reasonable and prudent alternatives, and any conservation recommendations with the Federal agency and any applicant on an informal basis. If revisions to the opinion are necessary, consultation can be reinitiated and a revised opinion issued.

"Incidental take" has been clarified in the final rule as those takes that result from, but are not the purpose of,

carrying out an otherwise lawful activity conducted by the Federal agency or the applicant. As requested by one commenter, the Service explains that otherwise lawful activities are those actions that meet all State and Federal legal requirements except for the prohibition against taking in section 9 of the Act. The Service believes that the definition, as clarified in the final rule, is adequate.

The definition of "informal consultation" has been clarified in the final rule to indicate that it is an optional process that includes all discussions, correspondence, etc., between the Service, Federal agency, and designated non-Federal representative prior to formal consultation. To address one commenter's concerns, "if required" has been included after "formal consultation" to clarify that formal consultation is not always required after informal consultation. Through informal consultation, a Federal agency may determine that formal consultation is not required.

The definition of "listed species" is adopted as proposed. Contrary to the concern of one commenter, aquatic invertebrates are not excluded from this definition, because all listed species in 50 CFR 17.11–17.12 are specifically included.

The definition of "major construction activity" was included in the definition of biological assessment in the proposed rule and is adopted substantially as proposed. As suggested by many commenters, it has been made a separate definition. Whether a Federal action is a major construction activity, as defined in these regulations, is the standard used for determining whether a Federal agency must prepare a biological assessment. A "major construction activity" is defined as a construction project (or other undertaking having similar physical impacts) that is a major Federal action significantly affecting the quality of the human environment for purposes of NEPA. The term encompasses dams, buildings, pipelines, roads, water resource developments, channel improvements, and other such undertakings which significantly modify the physical environment.

A vast array of comments were received concerning the scope of a major construction activity that requires the preparation of a biological assessment. Several commenters noted that only major Federal actions requiring the preparation of an environmental impact statement (EIS) pursuant to NEPA should require the preparation of a biological assessment under section 7(c) of the Act. Other commenters argued that assessments can only be required for major Federal actions involving construction activities, and suggested that the phrase "or other undertakings having similar physical impacts" be eliminated from the definition. Four commenters thought that the standard in the proposed rule was too narrow, because the limitation to major Federal actions, and/or the limitation to construction projects and other undertakings having similar physical impacts, were arbitrary and without legal basis. The Service has adopted the definition of major construction activity as proposed for the reasons set out below.

The legislative history of section 7(c) of the Act plainly focused the mandatory duty to prepare biological assessments on "major Federal actions . . . designed primarily to result in the building or erection of dams, buildings, pipelines and the like." H.R. Conf. Rep. No. 697, *supra*. The two-pronged regulatory test adopted in this rule—major Federal action *and* construction project (or other undertaking having *similar* physical impacts)—clearly tracks the quoted language from the Conference Report to the 1979 Amendments. The Service will not require biological assessments for projects that are not major Federal actions for purposes of NEPA. Further, the Service will not require biological assessments for actions that do not involve construction or activities having physical impacts similar to construction, such as dredging, blasting, etc. This limitation derives support from the 1979 Conference Report reference to actions designed *primarily to result* in the building or erection of various projects. These other "potentially destructive activities," H.R. Rep. No. 1625, *supra*, having physical impacts similar to construction projects, will require the preparation of an assessment, but only if they are major Federal actions for purposes of NEPA.

The Service declines to limit the scope of the definition of a major construction activity to major Federal actions involving construction projects, because other potentially destructive activities that are major Federal actions may have similar physical impacts and should be included. The Service is confident that the courts will be able to apply this standard consistent with the Act and the legislative history.

Contrary to the belief of one commenter, the Service has not abrogated its authority under section 7(c). That commenter urged the Service to change this rule by requiring biological assessments "for actions that, taking into consideration cumulative effects, may be 'potentially destructive.' " Citing a February 1980 legal opinion issued by the Assistant Solicitor for Fish and Wildlife, Department of the Interior, the commenter noted that cumulative effects may trigger the requirement that an assessment be prepared, although the Service must defer to the Federal agency's decision on whether a major Federal action exists. Contending that Congress would have used the word "shall" instead of "may" in the last sentence of section 7(c)(1) if it had intended that assessments be required only for major Federal actions for purposes of NEPA, the commenter argued that the definition of "major construction activity" should be expanded:

> "Major Construction activity" means any planned, temporary, or permanent physical modification to the environment. Examples of such projects include but are not limited to; dredging, drilling, filling, mining, site preparation, road construction, the erection of structures such as dams and buildings, or any other potentially destructive activities.

The commenter's suggested language goes well beyond the above-cited legislative history of the Act which clearly limited the biological assessment requirement to major Federal actions within the meaning of NEPA that are construction projects or that involve similar physical impacts. Further, the legal opinion of the Assistant Solicitor cited by the commenter does not support the commenter's argument because that opinion dealt with cumulative effects of a proposed *construction* project and a basic rule of NEPA case law that cumulative impacts of an action can trigger the requirement that an EIS be prepared. Thus, the basic elements of this rule's requirements—major Federal action (*e.g.*, EIS, or the functional equivalent, required) *and* construction project (or activity involving similar physical impacts)—were assumed to be appropriate standards by the Assistant Solicitor. The use of the word "may" instead of "shall" in section 7(c) means nothing more than Congressional intent that the duty to coordinate these review processes is discretionary with the Federal agency.

As requested by one commenter, the final definition clearly states that an action must be both a major Federal action for purposes of NEPA *and* a construction project (or other activity involving similar impacts). Therefore, it plainly follows that, although dams, pipelines, etc. are construction activities, a biological assessment is not

required unless the action is also a major Federal action.

Two commenters argued that OCS leasing, exploration, and development/production activities should be exempt from the section 7(c) requirement because such an analysis is presently covered by NEPA compliance as addressed in the Outer Continental Shelf Lands Act. Other commenters agreed with the Service that biological assessments would be required for development/production activities on the OCS, and, generally, would not be required for leasing and exploration activities that do not involve a significant modification of the physical environment. The Service adopts its position as proposed, because no exemption exists under section 7(c) if a biological assessment is required for an action. In some instances, OCS exploration activities may require the preparation of a biological assessment; *e.g.*, major Federal action involving exploration through construction of artificial gravel islands. However, in most cases major Federal exploration activities on the OCS will involve the drilling of test wells, actions that will not require the preparation of assessments.

The definition of "preliminary biological opinion" is adopted as proposed.

The definition of "proposed critical habitat" is adopted as proposed with the addition of the phrase "or revised" after "designated." The commenter that suggested this correction accurately noted that proposals may be made to designate or revise critical habitat under section 4 of the Act.

The definition of "proposed species" is adopted as proposed.

"Reasonable and prudent alternatives" is defined in the final rule. Section 7(b) of the Act requires the Service to include reasonable and prudent alternatives, if any, in a "jeopardy" biological opinion. An alternative is considered reasonable and prudent only if it can be implemented by the Federal agency and any applicant in a manner consistent with the intended purpose of the action, and if the Director believes it would avoid the likelihood of jeopardizing the continued existence of listed species or resulting in the destruction or adverse modification of critical habitat of such species. Further, the Service should be mindful of the limits of a Federal agency's jurisdiction and authority when prescribing a reasonable and prudent alternative. An alternative, to be reasonable and prudent, should be formulated in such a way that it can be implemented by a Federal agency consistent with the scope of its legal authority and jurisdiction. However, the Service notes that a Federal agency's responsibility under section 7(a)(2) permeates the full range of discretionary authority held by that agency; *i.e.*, the Service can specify a reasonable and prudent alternative that involves the maximum exercise of Federal agency authority when to do so is necessary, in the opinion of the Service, to avoid jeopardy. The Service recognizes that economic and technological feasibility are factors to be used in developing reasonable and prudent alternatives, as requested by one commenter. The definition of "reasonable and prudent alternatives" has been amended to reflect these considerations. If there are no alternatives that meet the definition of "reasonable and prudent alternatives," the Service will issue a "jeopardy" biological opinion without alternatives.

Two commenters stated that reasonable and prudent alternatives should include mitigation measures designed to reduce adverse effects, *i.e.*, conservation recommendations. One of those commenters urged the Service to limit the scope of recommended alternatives to those "consistent with the scope, magnitude, and duration of the project as well as the extent of its adverse effects." First, because there is a distinction between "reasonable and prudent alternatives" (that satisfy section 7(a)(2)) and "conservation recommendations" (that are authorized by section 7(a)(1)), the Service declines to include conservation measures within the scope of the definition. Second, the Service agrees that reasonable and prudent alternatives should be consistent with the intended purpose of the action and should therefore be economically and technologically feasible, but the Service cannot limit its range of choices to the criteria suggested by the commenter. Reasonable and prudent alternatives must cover the full gamut of design changes that are economically and technologically feasible for an action, independent of who is sponsoring the action.

Two commenters asked that "reasonable and prudent measures" be defined, and the Service has inserted a definition in the final rule. This addition clarifies the distinction between "reasonable and prudent alternatives" included in a "jeopardy" biological opinion and "reasonable and prudent measures" provided in an incidental take statement. The Service agrees with several commenters that reasonable and prudent measures are not the same as reasonable and prudent alternatives. Substantial design and routing changes—appropriate only for alternatives to avoid jeopardy—are inappropriate in the context of incidental take statements because the action already complies with section 7(a)(2). The commenter that advocated an "alternatives" approach for reasonable and prudent measures misapplied the legislative history of the 1982 Amendments. Reasonable and prudent measures were intended to minimize the level of incidental taking, but Congress also intended that the action go forward essentially as planned. Therefore, the Service believes that they should be minor changes that do not alter the basic design, location, duration, or timing of the action. The section 7 obligations of Federal agencies are not expanded by the application of reasonable and prudent measures, which strictly govern the scope of the section 9 exemption for incidental takings.

The definition of "Service" is adopted as proposed.

Section 402.03 Applicability.

This section, which explains the applicability of section 7, implicitly covers Federal activities within the territorial jurisdiction of the United States and upon the high seas as a result of the definition of "action" in §402.02. The explanation for the scope of the term "action" is provided in the discussion under §402.01 above.

Section 402.04 Counterpart Regulations.

The Service has retained the counterpart regulations section of the 1978 rule as the new §402.04 that authorizes the drafting of joint counterpart regulations by Federal agencies and the Service. "These counterpart regulations would allow individual Federal agencies to 'fine tune' the general consultation framework to reflect their particular program responsibilities and obligations." 43 FR 870, 871 (Jan. 4, 1978).

Counterpart regulations must be published first as proposed rules with a minimum 60-day public comment period. Such counterpart regulations must retain the overall degree of protection afforded listed species required by the Act and these regulations. Changes in the general consultation process must be designed to enhance its efficiency without eliminating ultimate Federal agency responsibility for compliance with section 7. As long as the general consultation process is used as a starting point, Federal agencies can anticipate little difficulty in securing approval of the Service for counterpart regulations.

One Federal agency commented that the counterpart regulation process is a time-consuming alternative. The Service admits that informal rulemaking takes time and effort, but believes that the "fine tuning" that could occur through the development of counterpart regulations might, in the long run, provide a solid return in time and resources saved through the use of a more compatible consultation procedure.

Section 402.05 Emergencies.

Section 402.05 provides a modified consultation procedure for the Service to respond to emergency situations. This provision applies to situations involving acts of God, casualties, disasters, national defense or security emergencies (added to the rule in response to public comments), etc.

Upon request by the Federal agency, the Service may carry out consultation through procedures other than those provided under these regulations, as long as such emergency procedures are consistent with sections 7(a)–(d) of the Act. This allows, for example, consultation through informal means (*e.g.*, a telephone call) and, therefore, rapid responses to emergency situations.

Several commenters suggested that specific procedures should be set out to provide guidance to Federal agencies facing emergency situations. One commenter suggested that consultation could be initiated informally, such as through a telephone call, and the Service could then communicate its information and recommendations over the telephone. Because of the severe time constraints inherent in an emergency, this informal approach is the method the Service anticipates will be used by a Federal agency to conduct a consultation for a *bona fide* emergency. One commenter felt that minimum requirements should include "documentation of the nature of the emergency and justification for an expedited consultation." The Service agrees and has required, in a new paragraph (b) to this section, that the nature of the emergency and the justification for using an expedited process be documented and forwarded to the Service. However, the Service has not required that this be done during the emergency or expedited consultation, as this may not always be possible. The new paragraph (b) requires that the Federal agency conduct an "after the fact" consultation. The Service will evaluate the information submitted by the Federal agency, *i.e.*, the nature of the emergency actions, justification for the expedited consultation, and an evaluation of the impacts to listed species and critical habitat, and issue a biological opinion including the information and recommendations given during the emergency consultation. This will serve not only to document fully the consultation, but may assist the Federal agency in responding to similar emergencies.

One commenter argued that, when dealing with a fire, flood, earthquake, or storm, there is not enough time or opportunity for a Federal agency to undertake consultation through an alternate process determined by the Director to be consistent with section 7. The Service notes that the utmost flexibility is needed to handle the most extreme emergencies and believes that the informal process outlined in this section would satisfy the commenter's concern for the availability of prompt consultation and decisionmaking in emergency situations.

The Service further recognizes that it is sometimes necessary to take immediate steps to contain, limit, or alleviate an emergency in order to protect health, safety, and welfare prior to initiating any form of consultation. However, the Service would like to stress the fact that its early involvement is important in order to take advantage of its expertise in minimizing the effects of emergency response activities on endangered and threatened species. Federal agencies must exercise discretion when responding to an emergency as to when to consult with the Service. This will depend on the nature of the emergency and the actions that are immediately required. The Federal agency should contact the Service as soon as practicable, keeping in mind the informal nature of emergency consultation and Service expertise in minimizing the impacts of emergency response activities on endangered and threatened species.

Section 402.06 Coordination with Other Environmental Reviews.

This section on coordination with other environmental reviews contains paragraphs (a) and (b) of §402.10 and paragraph (c) of §402.17 of the proposed rule. The substance of these paragraphs has been adopted, but the format has been altered.

These regulations, following the 1978 rule, allow Federal agencies to coordinate their consultation, conference, and biological assessment responsibilities under the Act with the agency's responsibilities under other statutes such as NEPA (42 U.S.C. 4321 *et seq.*) or the Fish and Wildlife Coordination Act (FWCA, 16 U.S.C. 661 *et seq.*). The Service encourages Federal agencies to coordinate these responsibilities, but believes it is preferable to allow Federal agencies to do so in a manner that best conforms to their particular actions and which they believe is most efficient. Therefore, the sentences in the proposed §402.10(b) stating that biological assessments *should* be incorporated into the documents required by other statutes (such as NEPA) have been dropped from the final rule.

Several commenters applauded these paragraphs because the coordination of environmental reviews would reduce duplication of paperwork and save time. One commenter requested guidance on how a NEPA review of endangered species issues should be conducted. The Service is not in a position to provide criteria that will ensure adequate NEPA compliance on endangered species issues. The Service suggests that the commenter contact the Council on Environmental Quality, the agency in charge of NEPA compliance, to obtain such information.

Another commenter expressed concern that, in simplifying the consultation process, safeguards should be used to avoid potential abuse and substantive problems. The commenter feared that, without safeguards, NEPA compliance might be construed as being less necessary on endangered species matters. The Service is also concerned that it retain sufficient review capability to identify potential conflicts between proposed Federal actions and listed species. Therefore, it has slightly altered its consultation procedures in this final rule to ensure that all Federal actions that "may affect" listed species receive some degree of review under informal or formal consultation.

The concluding sentences of paragraph (a) emphasize that although, for example, a biological assessment can be incorporated into an EIS, the procedures of these regulations also must be satisfied to ensure adequate and timely analyses during the section 7 consultation process. These sentences also express the intent of the Service to avoid a fragmented analysis of environmental concerns through the Service's direct efforts to provide a coordinated review. The Service declines to delete these sentences as requested by several commenters.

Under paragraph (b), the Service agrees with a comment that the biological opinion should be stated in the final environmental impact statement or environmental assessment. A statement of the opinion may be a summary of its findings and conclusions, contrary to the fear of one commenter that the entire opinion must be repeated

in the text of the NEPA document. The Service does feel that the entire opinion should be attached as an exhibit to the NEPA document if completion time permits.

Section 402.07 Designation of Lead Agency.

This section, which governs the designation of a lead agency, is adopted from §402.10(d) of the proposed rule. One commenter requested that the section be amended so that only the lead agency is required to notify the Director that it will be conducting consultation on behalf of itself and all other cooperating agencies. The Service has adopted this suggestion.

Section 402.08 Designation of Non-Federal Representative.

A new §402.08 has been added to the final rule to clarify the role of the designated non-Federal representative and was derived from §§ 402.02 and 402.12 (a) and (b)(5) of the proposed rule. Because the designated non-Federal representative may or may not be the applicant, there is a difference in the role the representative can play in the consultation. If the representative is not the applicant, the information-gathering functions, through informal consultation (§402.13) and/or through the preparation of a biological assessment (§402.12), is the full extent of its participation. However, if the representative is an applicant, its role in consultation is two-fold. As the representative, it may conduct the information-gathering functions identified above; as the applicant, it may continue its participation into formal consultation.

If an applicant is involved and does not desire to be the designated non-Federal representative, the Federal agency and the applicant must agree on the party to be designated. The Director shall be notified, in writing, if a non-Federal entity has been designated to represent the Federal agency for the informal consultation or biological assessment procedures.

One commenter stated that prior notice to the Director of the designation of a non-Federal representative is unnecessary. The Service disagrees because there is a legitimate need for it to be certain of the Federal agency's concurrence in the representation. However, the Service notes that there is a degree of flexibility here; *i.e.*, designation in advance for a continuous action or for a group of related actions is acceptable. In response to one comment, the Service agrees that the designated non-Federal representative may only submit a species list under the biological assessment procedures (§ 402.12) if the Federal agency has, previously to or simultaneously with this notice, provided its written designation to the Director.

Another commenter questioned the Service's authority to conduct informal consultations with non-Federal representatives in place of the Federal agencies. The Service acknowledges that the Federal agency must retain the responsibility to initiate formal consultation along with its ultimate responsibility to ensure that its actions are not likely to jeopardize listed species, but the designation of a representative by the Federal agency to conduct informal consultation does not lessen these responsibilities or eliminate the Federal agency's duty to review its actions. Instead, the designation of a representative allows the Federal agency to coordinate all of its environmental reviews, thereby saving time and resources to obtain a single, comprehensive analysis of the action and its potential impacts. The agency must still review the work product and independently reach its own conclusions and decisions. The representative does the ground work (data compilation and synthesis); the Federal agency cannot delegate its duty to review, analyze, and formally consult.

Concerned that a conflict of interest could exist if applicants were allowed to be designated as non-Federal representatives, one commenter cited 40 CFR 1506.5(c) (NEPA regulation) as authority for eliminating applicants from the field of potential representatives. The Service declines to make the suggested change for the following reason. Section 7(c)(2) itself recognizes that exemption applicants (including permit or license applicants) may prepare biological assessments in cooperation with the Service and under the supervision of the Federal agency. This express statutory opportunity for "interested parties" (as applicants would always be) to prepare biological assessments runs counter to the NEPA rule and shows the clear Congressional intent in favor of full applicant involvement in the section 7 process. Although applicants may fill the role of non-Federal representatives, the ultimate responsibility for compliance with section 7 remains with the Federal agency. In response to one commenter, the regulations have been changed to eliminate the requirement that the Federal agency "participate in the preparation" of the biological assessment. The Service believes that the Federal agency may fulfill its responsibilities by providing guidance and supervision, and by independently reviewing and evaluating the work product of the applicant. Responsibility for carrying out negotiations with the Service may not be delegated to the applicant/representative, as suggested by this commenter. In addition, Federal agencies cannot delegate their role in initiating formal consultation, conference, or early consultation.

Section 402.09 Irreversible and Irretrievable Commitment of Resources.

Section 7(d) of the Act provides that, after initiation of consultation required under section 7(a)(2), the Federal agency and any applicant shall make no irreversible or irretrievable commitment of resources with respect to the Federal action which has the effect of foreclosing the formulation or implementation of any reasonable and prudent alternatives that would avoid violation of section 7(a)(2). This prohibition does not apply to actions affecting proposed species or proposed critical habitat. This mandatory restriction on commitment of resources is set out in §402.09 of the final rule (formerly §402.11 of the proposal). In response to comments, the language of the proposed rule was corrected to conform more closely to section 7(d). Another commenter requested that the sentence dealing with section 7(d) be amended by adding "measures" after the phrase "reasonable and prudent alternative[s]" to bring the regulation in line with the statute. The Service declines to make this change because it would tend to confuse "reasonable and prudent alternatives" that are included in jeopardy biological opinions with "reasonable and prudent measures" that are included in an incidental take statement under section 7(b)(4) of the Act. The proposed language describing the section 7(d) prohibition accurately implements the Act and is adopted in this final rule.

The proposed rule addressed the duration of the section 7(d) prohibition as follows:

> This requirement exists until: a "no jeopardy" biological opinion is issued by the Service . . . ; the Federal agency adopts reasonable and prudent alternatives; or an exemption is granted under section 7(h).

Proposed rule, 48 FR 29990, 30000 (June 29, 1983), *proposed to be codified at* 50 CFR 402.11. Several commenters asked for a clarification or expansion of these criteria that terminate section 7(d) restrictions. Noting that the Act is silent as to when the section 7(d) prohibition ceases, one commenter contended that the prohibition should end when consultation is terminated. Another commenter, concerned that the proposed language would deprive Federal

agencies of the responsibility and authority to determine compliance with section 7(a)(2), urged the addition of a fourth criterion that would terminate the section 7(d) prohibition if "the Federal agency determines that its proposed action will not jeopardize the continued existence of endangered and threatened species or adversely affect critical habitat." Another commenter went further and urged the Service to adopt other criteria where Federal agency compliance with section 7(a)(2) would remove the section 7(d) restriction. Two other commenters felt that the second criterion—adoption of reasonable and prudent alternatives—must be restricted to those recommended by the Service. They opposed allowing the Federal agency to formulate its own "reasonable and prudent alternatives" without Service approval in order to avoid the prohibition of section 7(d).

The commenters raise valid concerns that illustrate the need to reexamine the duration of the prohibition against the irreversible and irretrievable commitment of resources. First, the Service recognizes that, although its biological opinions issued by authority of section 7(b) are entitled to great deference, the ultimate decision of whether to proceed with an action in light of section 7 responsibilities rests with the Federal agency. The proposed language did preempt Federal agency discretion by placing an agency that disagreed with the conclusion of the Service's biological opinion in the awkward position of facing section 7(d) restrictions on its action, even though it had determined through its own analysis that the section 7(a)(2) standards were satisfied. Second, case law indicates that section 7(d)'s proscriptive force continues while Federal agency efforts to conform its action to the requirements of section 7(a)(2) are "ongoing." *See North Slope Borough* v. *Andrus*, 642 F.2d 589, 611 n.143 (D.C. Cir. 1980); *Conservation Law Foundation of New England, Inc.* v. *Andrus*, 623 F.2d 712, 714 n.1 (1st Cir. 1979). The final rule has been amended to provide that the section 7(d) prohibition is in force during consultation and continues until the requirements of section 7(a)(2) are satisfied.

Therefore, if a Federal agency receives a "no jeopardy" biological opinion from the Service or chooses any reasonable and prudent alternative recommended by the Service, the requirements of section 7(a)(2) are met and the section 7(d) prohibition expires. If the Federal agency disagrees with a "jeopardy" biological opinion or chooses an alternative not provided by the Service based on its own analysis, then the validity of the Federal agency's "no jeopardy" finding will decide whether section 7(a)(2) has been satisfied and whether section 7(d) no longer applies. If it is later determined that the finding is not valid, the Federal agency would be taking the risk of noncompliance with the Act.

Finally, one commenter asked that this section be amended to require Federal agencies to give written notice to the Service verifying that neither it nor any applicant involved has made any irreversible or irretrievable commitment of resources during consultation. The Act does not provide such authority, except arguably in the exemption process. A mandatory section 7(d) notice has not been adopted in this final rule regarding consultation procedures because section 7(d) is strictly prohibitory in nature and not consultative.

Subpart B—Consultation Procedures

There are five primary components within the section 7 consultation procedures—conference, early consultation, biological assessment, informal consultation, and formal consultation. Of these, only conference, formal consultation, and biological assessments may be required. Although a Federal agency may elect to use several of these procedures, they do not represent a mandatory, sequential process. As requested by one commenter, the following is a brief abstract of each component of the consultation process.

If a Federal agency determines that its action is likely to jeopardize the continued existence of any *proposed* species or result in the destruction or adverse modification of *proposed* critical habitat, the Federal agency is required to "confer" with the Service under §402.10. The purpose of a conference is to identify and resolve potential conflicts between an action and proposed species or critical habitat. The Service will make advisory recommendations on ways to minimize or avoid adverse effects. If the proposed species or proposed critical habitat is subsequently listed or designated, respectively, then the Federal agency must consider whether formal consultation under §402.14 is required.

"Early consultation" is an optional process that may be requested through the Federal agency by a prospective applicant to determine whether its proposed action is likely to jeopardize the continued existence of a listed species or result in the destruction or adverse modification of critical habitat. Early consultation occurs prior to a formal application for a Federal permit or license. Such early consultation is conducted between the Service and the Federal agency in cooperation with the prospective applicant. At the request of the prospective applicant, early consultation is initiated by the Federal agency responsible for issuing the permit or license and is generally conducted and concluded in the manner prescribed for "formal consultation." If the action is a "major construction activity," the biological assessment requirement of §402.12 must be satisfied before early consultation is initiated. After concluding early consultation, the Service will deliver its preliminary biological opinion to the Federal agency and the prospective applicant.

After formal application is made for the permit or license but before its issuance, the Federal agency should submit to the Service a written request that the preliminary biological opinion be confirmed as a final biological opinion under section 7(a)(2). If the Service determines that no significant changes have occurred in either the proposed action or the information available since early consultation, no new impacts are anticipated, and no new species have been listed or critical habitat designated since early consultation, it will confirm that the preliminary biological opinion remains accurate and shall be treated as a final biological opinion issued under section 7(b) of the Act. Consultation will terminate in accordance with §402.14(*l*). However, if the Service is unable to confirm the preliminary biological opinion due to any of the reasons outlined in §402.11, formal consultation on that action must be initiated under §402.14.

"Biological assessment" requirements apply to all major construction activities as defined in these regulations. Even if not required, Federal agencies may voluntarily prepare a biological assessment to assist them in fulfilling their section 7 responsibilities. Also, any person who wishes to apply for an exemption may voluntarily prepare such an assessment in cooperation with the Service and under the supervision of the appropriate Federal agency.

A biological assessment contains information concerning listed or proposed species or designated or proposed critical habitat that may be present in the action area and an evaluation of any potential effects of the action on such species and habitat. A biological assessment should be used in determining whether formal consultation or a conference is required.

"Informal consultation" includes all the contacts (discussions, correspondence, etc.) between the Federal agency or its designated non-Federal representative and the Service that take place prior to the initiation of any necessary formal consultation. Informal consultation may be used by the Federal agency in determining whether formal consultation under §402.14 or a conference under §402.10 is required.

"Formal consultation" is required under section 7(a)(2) of the Act. A Federal agency must initiate formal consultation if it determines that its action "may affect" any listed species or its critical habitat unless it determines through informal consultation or biological assessment procedures, with the written concurrence of the Service, that its action "is not likely to adversely affect" such species or habitat. If the action is a "major construction activity," the biological assessment requirement must be satisfied before formal consultation may begin. Formal consultation is concluded within 90 days or extended in accordance with the provisions of §402.14. Within 45 days after concluding formal consultation, the Service will deliver its biological opinion stating whether or not the action is likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat. If formal consultation results in a "jeopardy" biological opinion, reasonable and prudent alternatives, if any, will be included in the opinion.

These procedures are discussed more fully below, together with the sections governing post-consultation responsibilities of Federal agencies and the factors that require reinitiation of formal consultation. Specific public comments are treated on a section-by-section basis.

Section 402.10 Conference on Proposed Species or Proposed Critical Habitat.

The 1979 Amendments added the requirement in section 7(a)(4) that Federal agencies confer with the Service on any Federal action that is likely to jeopardize the continued existence of any *proposed* species or result in the destruction or adverse modification of *proposed* critical habitat. The purpose of this requirement is to identify and resolve potential conflicts between an action and proposed species or proposed critical habitat at an early point in the decisionmaking process. Conferences will be conducted on an informal basis between the Federal agency and the Service. The Service will make recommendations, if any, to minimize or avoid adverse effects of the action on proposed species or proposed critical habitat. These recommendations are advisory in nature, because the "jeopardy" prohibition of section 7(a)(2) does not apply until the species is listed or the critical habitat is designated. However, the Federal agency and any applicant should give serious consideration to implementing the recommendations since, if the species is later listed or critical habitat designated, the Federal agency must review its action, regardless of its stage of completion, to determine whether consultation is required. In certain instances the Federal agency and the Service may conduct the conference in such a thorough manner that it would satisfy the consultation requirements of section 7(a)(2) if the proposed listing or designation is subsequently completed.

The conference procedures are not repetitive of work performed in the preparation of a biological assessment, as suggested by three commenters. First, the conference requirement applies to all Federal actions, while the biological assessment requirement only applies to actions that are "major construction activities." Second, the conference requirement applies to proposed species and proposed critical habitat, whereas biological assessments are required only when listed species or critical habitat may be present in the action area (although proposed species or proposed critical habitat should be covered in the assessment if they also may be present in the action area). Thus, the conference process fills the need to alert Federal agencies of possible steps that the agency might take at an early stage to adjust their actions to avoid jeopardizing a proposed species. The Service strongly encourages the implementation of the recommendations so the action would not violate section 7(a)(2) if the species is listed or the critical habitat designated.

After reviewing a biological assessment or other available information, the Service may determine that a conference is required for the proposed species or proposed critical habitat. A sentence has been added to the new paragraph (b) of §402.10 [proposed §402.13(a)] to point out the Service's responsibility to request a Federal agency to confer after a review of available information. The last sentence of the proposed paragraph (a) has been deleted since the new §402.08 clearly defines the role of the designated non-Federal representative. The Service declines to take the position that it can "require" the initiation of a conference, because the Federal agency bears the ultimate responsibility to assess the likelihood of jeopardy to proposed species by its actions. However, the Service will vigilantly review biological assessments and other available information and fulfill its duty to make Federal agencies aware of their responsibilities under the Act.

The Service emphasizes the need for Federal agencies to confer because such efforts may not only minimize or avoid injury to proposed species but might also prevent the halting of an action if the species is subsequently listed:

> Obviously, Federal agencies irreversibly committing resources and foreclosing alternatives to an action that is likely to jeopardize a proposed species do so with the risk that the species will eventually be formally listed and the prohibitions of section 7 will become applicable. The conferees do not believe that any Federal agency or permittee should make any irreversible or irretrievable commitments of resources for the purpose or with the intent of foreclosing otherwise reasonable alternatives or in order to secure an exemption pursuant to section 7(h).

H.R. Conf. Rep. No. 697, 96th Cong., 1st Sess. 13 (1979).

There is no requirement that Federal agencies confer with the Service on species that are candidates for listing proposals. However, for the reasons identified by Congress in the Conference Report to the 1979 Amendments on proposed species, the Service encourages Federal agencies to confer informally on candidate species when deemed appropriate to avoid jeopardy and to avoid potential economic loss through project modification if the species is later listed.

Several specific changes were recommended for proposed paragraph (a) [paragraphs (a) and (b) in the final rule]. One commenter felt that the reference to "potential endangered species conflicts" was too restrictive. The Service agrees that the proposed rule might have been construed so as to exclude threatened species. Therefore, the sentence has been adjusted to refer to all potential conflicts.

One commenter urged the Service to change the standard for initiating a section 7(a)(4) conference from "likely to jeopardize" to "would adversely affect." The regulation tracks the statute. The Service lacks the authority to make the requested change.

Several commenters urged the Service to make provisions for applicant involvement in the conference process. The Service agrees, and has added language in paragraphs (a), (c), and (e) of §402.10 to ensure that applicants have an opportunity to participate in the

conference, and that they receive a copy of the conclusions documented by the Service.

Another commenter asked that time limits be established for the conference process. The Service declines to establish time limits for the conference requirement. The timing of the section 7(a)(4) process is, in part, dictated by the progress of the proposed rulemaking to list a species or to designate critical habitat. Regardless of any time limits that the Service could establish, the conference requirement expires and consultation is required if the listing or critical habitat designation becomes final. The Service finds no reason to impose rigid time frames for conferences.

Paragraph (c) defines the nature and content of the conference. Basically, a "conference" involves informal discussions on the identification and possible avoidance or minimization of potential adverse effects to proposed species or proposed critical habitat from a Federal action. The reference to "informal discussions" should not be confused with "informal consultation," which is a distinct, but optional, component of consultation.

The Service declines to modify paragraph (c) by changing "advisory" recommendations to "conservation" recommendations, as suggested. Such a change may confuse conference with formal consultation, the required procedure in which discretionary "conservation recommendations" may be given. The Service also declines to adopt suggested provisions that would (1) require advisory recommendations to be made in every conference, (2) force the Service to notify the Federal agency of the date on which a final decision will be made on a listing proposal, or (3) require the Service to initiate emergency rulemaking proceedings to list a species or designate critical habitat if the Federal action is likely to jeopardize the species. Although required, conference is an informal process that has no substantive force. To force every conference into a regimented structure would be counterproductive and contrary to the intent of the Act. When appropriate, the Service will make advisory recommendations on ways to avoid or minimize adverse effects to proposed species or proposed critical habitat. During the conference, the Service will apprise the Federal agency of the progress of the listing or critical habitat proposal and will attempt to notify the Federal agency when the listing or critical habitat proposal becomes final. Emergency rulemaking is provided for under section 4(b)(7) of the Act and will be used if appropriate under the circumstances.

One commenter suggested that the conference involve all of the steps of formal consultation, but on an informal basis so that if the listing becomes final, the conclusions and recommendations derived from the conference could be adopted as a final biological opinion. In some cases, a thorough, well-prepared conference might elucidate sufficient conclusions and recommendations to serve as the biological opinion, upon the final listing of a species. While section 7(a)(4) does not require Federal agencies to follow the section 7(a)(2) process for proposed species or proposed critical habitat, or specifically provide for the conversion of conference "conclusions and recommendations" into a final biological opinion [in contrast to explicit authority under section 7(b)(3)(B) for the conversion of preliminary biological opinions into final biological opinions], such a procedure is available to the Federal agency and the Service in appropriate instances.

If the information necessary to conduct a formal consultation is available at the conference stage, and if a formal procedure is deemed appropriate by both the Federal agency *and* the Service, the conference may be conducted through a procedure equivalent to formal consultation; the results, or opinion, derived from a "formal" conference may be adopted as the biological opinion when the proposed listing or designation is completed. It should be noted that the conference conclusions and recommendations would only be adopted as the biological opinion in those instances where no new data are developed, including that developed during the rulemaking process on the proposed listing or designation of critical habitat, and no changes to the Federal action are made which would alter the content of that opinion. By providing procedures which allow for a more extensive conference that may later be adopted as the biological opinion, the Service does not intend to expand upon the requirements of section 7(a)(4). Rather, this procedure is an option available to the Federal agency and the Service to help avoid conflicts and expedite consultation if the proposed species or critical habitat is listed or designated. Therefore, a new paragraph (d) is added to this final rule to acknowledge the availability of a "formal" conference procedure.

Paragraph (e) of §402.10 discusses the documentation of the results of the conference. If the action involves only proposed species or proposed critical habitat, a copy of the recommendations will be forwarded by the Service to the Federal agency and any applicant. If an action also involves formal consultation on listed species or critical habitat, the Service will provide the recommendations on proposed species or proposed critical habitat with the biological opinion. As requested by some commenters, the final rule has been clarified to state that the conclusions of a conference will be provided with the biological opinion rather than made an integral part of ("consolidated in") the opinion. The Service does not intend that the informal nature of the conference be changed or that any of the requirements of formal consultation under section 7 be imposed on Federal agencies with respect to proposed species or proposed critical habitats unless the Federal agency specifically requests a more formal procedure. Early initiation of these discussions increases the chances of resolution of potential conflicts.

Section 402.11 Early Consultation.

The 1982 Amendments added a provision to the consultation process [section 7(a)(3)] designed to identify and to minimize, early in the planning stage of an action, potential conflicts between the action and listed species. These early consultation provisions authorize the Service to consult with Federal agencies at the request of and in cooperation with prospective applicants regarding the impact of proposed actions on listed species or critical habitat. These provisions are incorporated into the final regulations in §402.11 (§402.14 of the proposed rule). The intent of this provision is to involve the Service and State and local planning and conservation entities in the planning stages of actions. The Service believes that early consultation will be helpful in establishing a mechanism for early resolution of potential conflicts. Congress did not intend that this provision be used to authorize consultation for speculative or remote actions but rather only on actions which are likely to occur. The regulations require prospective applicants to provide sufficient information describing the project, its location, the scope of activities associated with it, and the anticipated impacts to listed species to enable the Federal agency and the Service to conduct meaningful early consultations.

The opportunity for an early consultation should expedite the permitting and other regulatory processes associated with actions requiring Federal authorizations.

Contrary to the interpretation of one commenter, early consultation is not a required process, but rather is an optional step that a prospective applicant can take to factor in section 7 considerations during the initial planning stage. Although early consultation contains most of the features of formal consultation, the Service declines to adopt the suggestion to place the early consultation provisions within the formal consultation section as a "special case." Early consultation, unlike formal, is not required and occurs before any application for a permit or license is filed, whereas formal consultation is a post-application process when applicants are involved. These differences are significant and merit the separation of these distinct processes into separate sections. However, because of the extensive similarities in the procedures for early and formal consultation, the final rule has been substantially modified in format to reference appropriate paragraphs in §402.14 (formal consultation) to avoid repetition of these commom features. Although this has greatly shortened the early consultation section, the requirements and procedures have not been altered substantively.

One commenter was confused over the parameters of early consultation and informal consultation (§402.13). Informal consultation is a post-application process, as is formal consultation; early consultation is a pre-application process. There is no overlap. Designated non-Federal representatives can carry out informal consultation, and they can also carry out the biological assessment process if an assessment is required during the early consultation. Although only Federal agencies conduct early consultation directly with the Service, non-Federal representatives may continue to play a role in the data-gathering function of consultation.

Several commenters believed that proposed §402.14 took away the prospective applicant's right to request early consultation and to make the initial determination of possible impacts to listed species or critical habitat. The proposed rule preserved the prospective applicant's right to request early consultation but provided the Federal agency with the responsibility for determining impacts to listed species or critical habitat. In response to comments, the final rule has been rearranged to clarify the primary role of the applicant in making the initial determination and request to the Federal agency. However, the applicant's rights under section 7(a)(3) of the Act are not unqualified, and the ultimate burden is on the applicant to meet certain threshold criteria.

Paragraph (a) of §402.11 outlines the purpose of early consultation and is adopted substantially as proposed in §402.14(b) and the first sentence of §402.14(c). The legislative history is clear that the prospective applicant must be involved to the greatest extent practicable in every aspect of the early consultation process. H.R. Conf. Rep. No. 835, 97th Cong., 2d Sess. 26 (1982). One commenter expressed concern that it may not be possible to have the applicant involved in every meeting and telephone call between the Federal agency and the Service. Therefore, acknowledging the practical limitations on involving the applicant in all consultation contacts (but still recognizing the need for continuous communication with the applicant), the second sentence of paragraph (a) now reads that the prospective applicant should be involved "throughout" (instead of "in every aspect of") the consultation process.

Paragraph (b) of §402.11 sets out the threshold conditions that must be satisfied before early consultation can be initiated and is derived from proposed §402.14(c). As suggested by one commenter, the prospective applicant's request for early consultation should be made in writing to the Federal agency.

The "may adversely affect" threshold for initiating early consultation has been expanded to "may affect." This action was taken because the more restrictive standard unnecessarily limited access to this early review procedure, especially since at the early planning stage of an action the exact nature of a possible effect could be difficult to define.

Section 402.14(c) of the proposal established that the Federal agency ensure that the following conditions be met prior to initiation of early consultation:

(1) there must be a definitive proposal outlining the action and its effect;

(2) it must be shown that the action is technologically, administratively, and legally feasible;

(3) it must be shown that the applicant possesses adequate economic resources to conduct the action; and

(4) it must be shown that the applicant possesses some property interest in the proposed site on which the action will occur.

Numerous comments were received on these criteria. Three commenters urged the Service to strike all four conditions because of their unreasonableness and the Service's lack of authority to impose them on applicants. Other commenters criticized conditions (2) and (3) due to their ambiguity. Contending that enforcement of these conditions would preclude early consultation in many cases, the commenters noted that the information needed to meet these conditions is not available at the time that early consultation is most useful. The commenters also attacked condition (4), regarding the need to show an ownership interest in land, because early consultation would normally occur prior to the selection of an exact location for the project. Two commenters stated that conditions (1) and (2) are adequate for screening serious actions. One commenter suggested that only two criteria be addressed in determining eligibility for early consultation: scope of the project, and possible effects on listed species.

The Service was given explicit authority in section 7(a)(3) of the Act to issue guidelines that would prevent speculative or undefined actions from triggering early consultation.

> The Committee expects that the Secretary will exclude from such early consultation those actions which are remote or speculative in nature and to include only those actions which the applicant can demonstrate are likely to occur . . . . The Committee further expects that the guidelines will require the prospective applicant to provide sufficient information describing the project, its location, and the scope of activities associated with it to enable the Secretary to carry out a meaningful consultation.

H.R. Rep. No. 567, 97th Cong., 2d Sess. 25 (1982).

The final rule retains proposed condition (1) that requires the nature and effect of a prospective action to be defined. Without adequate information, early consultation would be meaningless. Proposed condition (2) has been modified in the final rule to require that the prospective applicant certify that it intends to implement its proposal, if authorized. This will prevent highly speculative actions from entering early consultation. The Service believes that these two conditions are reasonable and will allow Federal agencies and the Service to focus their attention on concrete, feasible actions through meaningful, early consultations.

Proposed conditions (3) and (4) described above have been deleted. The Service agrees that these conditions went beyond the normal pre-application information-gathering practices of Federal agencies and that they might have discouraged early consultations unnecessarily.

Paragraph (c) of §402.11 is adopted from proposed §402.14(a) and the introductory paragraph of proposed §402.14(d). This paragraph governs initiation of early consultation by the Federal agency if the prospective applicant complies with paragraph (b).

Paragraph (d) of §402.11 governs the procedures for conducting early consultation. To eliminate unnecessary regulatory language, this paragraph cross-references the items in §402.14(c)–(j), since the general consultation requirements are the same as for formal consultation. The proposed rule repeated these requirements in §402.14 (d) through (i).

One commenter argued that the Service exceeded its authority in proposed paragraph (d)(3) by telling Federal agencies how to meet their responsibilities by requiring Federal agencies to involve the applicant in the data-gathering function. Although this is not included in the final rule, the Federal agency has an underlying responsibility to involve the applicant in every aspect of the early consultation to the extent possible. Moreover, the applicant may be the primary source of data used in the consultation.

If the action is a major construction activity, then a biological assessment must be prepared in accordance with §402.12 before the request for early consultation is submitted, as is required for formal consultation. This is a change from proposed §402.12(b)(10), which made the biological assessment optional during early consultation. The Service agrees with the comment that, for major construction activities, a meaningful early consultation must include the preparation of a biological assessment because the preliminary biological opinion issued after early consultation may be confirmed as the final biological opinion. Therefore, if early consultation is requested for a major construction activity, the Federal agency must complete a biological assessment under §402.12 prior to submitting its request for early consultation.

The time limits and extension provisions for formal consultation are incorporated by reference as the requirements for early consultation. Several commenters felt that the "mutually agreed upon" language of the proposal [§402.14(e)] was too loose and that definitive time limits were needed. The Service agrees and has adopted the time limits for formal consultation to apply to early consultation as well. The Service notes that, for major construction activities, the time period will not begin to run until the biological assessment under §402.12 is completed. Because time deadlines have been adopted, there is no need to require a written notice that consultation has been concluded, as requested by one commenter.

Proposed §402.14(i) concerned requests by the Service for additional data, and did not require the addition of a written notice procedure for obtaining an extension. This is now required, as requested by one commenter, by incorporating the formal consultation requirements.

Proposed §402.14(f) recognized that the Service's responsibilities during early consultation are the same as those that exist during formal consultation. The final rule retains this provision by reference. The Service is opposed to limiting the scope of its analysis of impacts during early consultation, and it is also opposed to limiting the free flow of communication among it, the Federal agency, and the applicant. Therefore, the comment suggesting that draft preliminary biological opinions not be released to the Federal agency or the prospective applicant is rejected. This is not an issue that can be dealt with on an ad hoc basis, depending on the program experience with particular agencies or regions. The policy behind early consultation is clear: full involvement of all parties, including the prospective applicant, to identify and eliminate conflicts at the earliest possible stage of a project.

Paragraph (e) of §402.11 provides that the contents and conclusions of a preliminary biological opinion are the same as for a biological opinion issued after formal consultation in §402.14(i). One commenter stated that biological opinions need only be issued after formal consultation under section 7(a)(2) of the Act and that this should be clarified in the rule. The Service disagrees because a "written statement" containing the Secretary's opinion is required to be given after the conclusion of both early and formal consultation. However, there is an important difference in these two types of opinions: the former has no independent, operative significance, while the latter states the Service's "final" judgment on the impacts of an action. The preliminary biological opinion, issued after the conclusion of early consultation, has no operative force until it is later confirmed by the Service under section 7(b)(3)(B) of the Act, just before the action is to be taken.

One commenter said that it is inappropriate to include an incidental take statement with a preliminary biological opinion. The Service believes that input on incidental take is essential to adequately assist the applicant in planning its action. It would be unfair to force the applicant to wait until the time for confirmation of the preliminary biological opinion to receive its first notice on the terms and conditions that must be complied with and the amount and extent of permissible incidental take. No harm results to the species by providing this statement in the preliminary biological opinion because, as stated in the rule, it does not constitute a permit to take. The "taking" exemption under section 7(o)(2) does not occur until the preliminary biological opinion is later confirmed as a final opinion under §402.11(f).

Paragraph (f) of §402.11 is adopted from proposed §§ 402.15(b) and 402.18(a). This paragraph acknowledges that, if certain findings are made by the Service, a preliminary biological opinion may be confirmed as a final biological opinion after formal application for a Federal license or permit is made. The rule requires the Service to make its decision on confirmation within 45 days after receipt of the Federal agency's request. As requested by one commenter, both the request and the Service's response must be in writing.

Section 402.12 Biological Assessment.

This section explains the biological assessment requirements under section 7(c) of the Act and the process that must be followed in its preparation. The requirement that biological assessments be prepared in advance of certain consultations under section 7(a)(2) was added by the 1978 Amendments. Although the Service has, as a matter of agency practice, been requiring the preparation of biological assessments in appropriate cases under the authority of section 7(c), this final rule consolidates all regulatory requirements pertaining to biological assessments.

The proposed rule addressed the biological assessment provisions in §§402.01(c) and 402.12(b). In response to public comments, the Service has merged these sections in the final rule into § 402.12. The new format clarifies the requirements and procedures for preparing biological assessments. Although the organization of these provisions has been changed substantially, the substance of the regulation is, except for minor amendments, the same as that presented in the proposed rule.

The informal consultation and biological assessment processes were both presented in §402.12 of the proposed rule. This confused several commenters who believed that biological assessments could only be performed in conjunction with informal consultations. To eliminate this

confusion, the biological assessment provisions are placed in a separate section, immediately before informal consultation. Although a Federal agency may prepare a biological assessment while involved in informal consultation with the Service, there is no requirement that it do so.

References to conference, early consultation, and formal consultation in proposed §402.12 (b)(7) (third through fifth sentences) and (b)(10) have been deleted because cross-references to the biological assessment requirement have been inserted in §§402.10, 402.11, and 402.14 to explain the interrelationship of these processes.

The purpose of a "biological assessment," as stated in §402.12(a), is to evaluate the potential effects of the action on listed or proposed species or designated or proposed critical habitat and determine whether any such species and habitat are likely to be adversely affected by the action. Biological assessments are designed to assist Federal agencies in "determining whether section 7(a)(2) consultation should be initiated by identifying endangered or threatened species that may be present in the area affected by their proposed project and by identifying the impacts of those projects on such species." H.R. Rep. No. 697, 96th Cong., 1st Sess. 14 (1979). Such assessments are designed to promote the "early discovery of and elucidation" of potential endangered and threatened species conflicts with proposed agency actions. These reviews should take place well before the agency exercises its discretion to authorize, fund, or carry out an action. H.R. Rep. No. 1625, 95th Cong., 2d Sess. 20 (1978).

One commenter asked that a reference be inserted for preparation of "preliminary biological assessments." The Service does not require advance review of draft biological assessments; the requested procedure would add to statutory requirements. Therefore, the addition has not been made.

Section 402.12(b)(1) of the final rule acknowledges that the Act exempts from the biological assessment requirement those actions for which contracts were let or construction was started on or before the effective date of the 1978 Amendments. One commenter argued that the assessment requirement must not be retroactive, but should apply only to current actions as of the issuance of the final rule. The Service must follow the Act on this point and adopt the rule as proposed. This will not operate to the disadvantage of any Federal agency involved in a section 7 consultation, because the Service has been requiring the preparation of biological assessments since the effective date of the 1978 Amendments.

Section 402.12(b)(1) also recognizes that virtually any Federal agency, State or local agency, private organization, or individual (potential exemption applicants) may voluntarily prepare a biological assessment consistent with the procedures set forth in this section to assist it in fulfilling its section 7 responsibilities. One commenter urged the Service to delete the sentence referring to voluntary preparation of assessments in proposed §402.12(b)(1) because consultation is terminated if a biological assessment is not *required*. The commenter's statement is only true for an action if no listed species or critical habitat are present in the proposed action area. The placement of that sentence in the proposed rule was confusing, and thus the final rule has been clarified. The Service would like to make it clear, however, that whether a biological assessment is required or voluntary bears no relation to whether a conference or formal consultation is required under §§402.10 or 402.14, respectively. The assessment is a tool used to identify impacts to species or habitat so that a decision can be made as to whether a proposed action is likely to adversely affect listed species or critical habitat. The biological assessment can be used to determine whether a conference or formal consultation is required.

The Act provides that any person who may wish to apply for an exemption from the requirements of section 7(a)(2) may voluntarily conduct such an assessment, in cooperation with the Service and under the supervision of the appropriate Federal agency. These potential exemption applicants must follow the procedures described in §402.12. Under section 7(h)(2), an exemption is not permanent unless a biological assessment has been prepared. A permanent exemption remains in force for a particular Federal action regardless of the listing of additional species in the action area, whereas an ordinary exemption is limited to the species involved in the section 7 consultation. Paragraph (b)(1) acknowledges these statutory provisions.

Therefore, the Service retains the flexibility inherent in paragraph (b)(1) that allows for the preparation of biological assessments in those instances where they are not specifically required by this rule. Although requested by another commenter, the Service declines to set guidelines for the exercise of discretion by other Federal agencies or applicants on the decision to voluntarily prepare assessments.

Paragraph (b)(2) has been added in response to public comments. The limitation in section 7(c)(1) of the Act on entering contracts or starting construction on an action while the preparation of a biological assessment is pending has been included in these regulations. This construction restriction applies to all actions involving the preparation of a biological assessment.

The fact that a biological assessment is not required for all actions does not mean that listed or proposed species or designated or proposed critical habitat receive less protection. Federal agencies still have an obligation to review all of their actions to determine whether formal consultation under §402.14 is required. In addition, Federal agencies must confer on actions that are likely to jeopardize the continued existence of proposed species or result in the destruction or adverse modification of proposed critical habitat.

One commenter asked that Federal agencies be required to document any finding of "no effect" on listed species or critical habitat for actions not involving the preparation of a biological assessment. The Service has no authority to impose such a requirement, but does encourage Federal agencies to use their NEPA documentation to illustrate their analysis of Endangered Species Act issues.

The Service reserves the right to request that an agency prepare a biological assessment. One commenter questioned the right of the Service to request assessments when such are not otherwise required by the Act. Another commenter feared that the Service would routinely request field studies with many of the characteristics of biological assessments, regardless of the action's potential effects, the acceptability of a general field reconnaissance, or the obligation of the Service to provide guidance and data. The Service's request for a biological assessment or for field studies is not of mandatory effect; a Federal agency may reject any such request. The Service recognizes that consultation involves a two-way flow of information. It will always strive to provide data that are available and to assist in designing or in conducting studies (within budgetary constraints and available staffing) or in gathering data through consultation.

Paragraph (c) of §402.12 covers the request by a Federal agency for a species list from the Service. This paragraph was adopted from §402.12(b)(1) (first sentence) of the proposed rule. Paragraph (d) of §402.12

involves the Director's issuance of a species list. This paragraph was adopted from §402.12(b)(2) of the proposed rule.

The biological assessment process begins when a Federal agency decides that its action is a major construction activity, as discussed in these regulations, or it decides that it will voluntarily prepare a biological assessment. The Federal agency or the designated non-Federal representative requests information on whether listed or proposed species or designated or proposed critical habitat may be present in the action area. Within 30 days of receipt of that inquiry, the Director will respond with a list of any such species and critical habitat that may be present, as well as the available data (or references thereto). This may include recommendations for studies or surveys that may assist in the preparation of the biological assessment.

Contrary to the contentions of several commenters, the request for a species list is mandatory under section 7(c) for any major construction activity, unless the Federal agency forwards its own list for the Director's concurrence as explained below. This is not a burdensome requirement, even for apparent "no effect" actions, since the entire process, including the Director's response that no listed species or critical habitat occurs in the action area, may be carried out without delay through the NEPA process.

In response to comments, the final regulations explicitly allow the Federal agency or the designated non-Federal representative to proceed with the preparation of the biological assessment prior to receiving a species list from the Service. In this situation, the Federal agency or the designated non-Federal representative is required to notify the Director in writing as to the species and critical habitat that are being included in the assessment. As recommended by three commenters, the Service will respond to this notification in writing within 30 days as to whether it concurs with the species and critical habitat to be covered in the biological assessment.

One commenter suggested that an applicant should have an opportunity to informally request a species list to assist it during the planning stage of a project. Then, if the applicant begins preparation of a biological assessment within 90 days of receipt of this "informal" list, the commenter thought that the Service should not amend the list at a later time. The commenter appears to be advocating an opportunity for early consultation, which is provided for under §402.11 of this final rule.

Nevertheless, the request that a species list not be modified once issued might backfire on the applicant, because §402.14 requires consultation on all listed species and critical habitat that may be affected by a Federal action. Even if a species is inadvertently omitted from the species list and biological assessment, the Act nevertheless requires that it must be considered in satisfying the requirements of section 7(a)(2). Thus, the sooner the Service notifies the applicant of additional species to be included in a required biological assessment, the sooner the consultation will be completed.

In addition to listed or proposed species or designated or proposed critical habitat, the Service will include candidate species in the species list. Candidate species are those species being considered for listing but not yet the subject of a proposed rule. This will inform the Federal agency and any applicant of potential proposals for listing. Candidate species have no legal status and are accorded no legal protection under the Act, and thus the Federal agency need not include them in a biological assessment. However, should a candidate species become proposed or listed prior to completion of the action, a conference or formal consultation may be required.

Several commenters asked that species lists be "site-specific" and not regional in scope. One of these commenters urged the Service to include only species actually known or believed to occur in the action area. The Service agrees that the species list should be tailored to the action area and that field personnel should take care that the list is not overinclusive. However, the Act requires the Service to provide a list of all listed or proposed species that "may be present" in the action area. Thus, migratory species that "may be present" at some point within the action area must be included in the species list.

Another commenter said that the Service should include only species in the list that it believes may be affected by the action. This approach is not consistent with section 7(c), which requires a disclosure of all species that "may be present" in the action area. The comment would also eliminate the Federal agency's right to make an initial evaluation of possible effects to each species.

One commenter's conclusion that a determination of no adverse effect after receipt of the species list, but before preparation of the assessment, eliminates the need to prepare the assessment and concludes consultation is erroneous. The biological assessment is used to determine whether an activity "is likely to adversely affect" listed species or critical habitat. Consultation does not conclude unless the Service concurs in writing with the finding of the biological assessment indicating that the action is not likely to adversely affect listed species or critical habitat.

The Service has clarified paragraph (d)(1) to accommodate the concern of the House Committee that biological assessments not be required on major construction activities affecting proposed species or proposed critical habitat only. However, if a species list includes both listed and proposed species, each must be considered in the biological assessment as required by section 7(c) of the Act.

Concerned that the Federal agency should receive all information during the assessment process, one commenter asked that the species list be delivered to both the Federal agency and its designated non-Federal representative due to the agency's responsibility to supervise the preparation of the assessment. The Service declines to include this requirement in the rule, but will forward a copy to the Federal agency, if requested. It is the Federal agency's responsibility to decide whether it wants to designate a non-Federal representative, and if one is designated, the species list will be sent to the representative as requested by the Federal agency.

Several commenters suggested that the Service's ability to recommend "necessary" studies or surveys would contravene the "best available scientific and commercial data" standard of section 7(a)(2). The Service agrees that the proposed language may have implied that additional studies or surveys were required or necessary to complete the assessment. Therefore, the sentence is changed to state that the Service may recommend studies or surveys that it believes would assist in the preparation of the assessment. A new sentence is also added to clarify that such a recommendation is not to be construed as the Service's opinion that the Federal agency has failed to satisfy the information standard of section 7(a)(2) of the Act. This change preserves the Service's prerogative to request further studies if deemed appropriate, while recognizing the ultimate responsibility of the Federal agency to secure the best available data. Two commenters suggested that the request for studies be limited to studies necessary to locate and assemble already existing data. The Service declines to so limit the scope of studies it may request.

Paragraph (e) of §402.12 is carried over from §402.12(b)(3) of the proposal.

It requires a party preparing a biological assessment to verify its species list with the Service if, after 90 days from the receipt of or concurrence with the species list, it has yet to commence the preparation of the assessment. A written verification, as suggested by one commenter, is not required since that would be tantamount to issuing a second species list, contrary to the informal nature of this verification step. The Federal agency may, on its own, document the verification received under this paragraph in its administrative record. As requested by one commenter, the Service has distinguished the initiation of the biological assessment time period (time of receipt of or concurrence with a species list) from the point at which actual preparation of the assessment is begun.

Based on comments received, a new paragraph (f) entitled "contents" has been added. Some commenters argued that Federal agencies should be required to include certain minimum research methods or activities in the preparation of a biological assessment. One commenter suggested that preparers of biological assessments should:

(a) conduct a scientifically sound on-site inspection of the area affected by the action, which must, unless otherwise directed by the Service, include a detailed survey of the area to determine if listed or proposed species are present or occur seasonally and whether suitable habitat exists within the area for either expanding the existing population or potential reintroduction of populations;

(b) interview recognized experts on the species at issue, including those within the Fish and Wildlife Service, the National Marine Fisheries Service, State conservation agencies, universities and others who may have data not yet found in scientific literature;

(c) review literature and other scientific data including recovery plans if available to determine the species' distribution, habitat needs, and other biological requirements;

(d) review and analyze the effects of the action on the species, in terms of individuals and populations, including consideration of the indirect and cumulative effects of the action on the species and habitat;

(e) analyze alternate actions that may provide conservation measures; and

(f) conduct any studies necessary to fulfill the requirements of (a) through (e) above.

The Service agrees that assessments should be as complete and thorough as possible, but declines to impose strict minimum standards that all biological assessments must satisfy. The above-listed activities, which may be performed in preparing an assessment, are endorsed by the Service as items that a model assessment would include. However, the nature of the Federal action may not warrant carrying out all of these research activities or studies, and some of the steps may not be technologically feasible in certain cases. Therefore, the new paragraph (f) only contains suggestions of what a Federal agency may include in a biological assessment.

One commenter asked the Service to explain the difference between the degree of information needed in a biological assessment and the degree of information needed to initiate formal consultation when the action does not require the preparation of an assessment. In both cases the overall information standard is the same: "best scientific and commercial data available." The difference arises in the process. If a biological assessment is prepared, it must include not only the data but also a synthesis of the data involving an analysis of the effects of the action. Basically, the assessment serves as an analytical instrument and can be used by the Federal agency "to build its case" as to whether a particular action is likely to adversely affect a listed species or its critical habitat. If the Service concurs with a determination of "not likely to adversely affect," then formal consultation is not required. If an assessment is not required, the Federal agency need only submit data to the Service to initiate formal consultation pursuant to § 402.14(c).

Paragraph (g) of §402.12, which deals with the authority to incorporate earlier biological assessments by reference as the assessment for a current proposal, is adopted from the last two sentences of proposed §402.12(b)(1). In those instances where a proposed Federal action is identical, or very similar, to a previous action for which a biological assessment was prepared, the Federal agency may not need to prepare a new biological assessment.

One commenter requested that language be added to clarify that a previous biological assessment being incorporated by reference could have been part of a prior EIS or area-wide assessment. The Service declines to make the change noting that the form of the previous biological assessment (whether in an EIS or other document) has no bearing on whether it meets the conditions for incorporation by reference.

In response to comments, the conditions that must be met for incorporation by reference are clarified. The biological assessment requirement may be fulfilled by incorporating by reference the earlier biological assessment and supporting data into a written certification that: (1) the proposed action involves similar impacts to the same species in the same geographic area; (2) no new species have been listed or proposed or critical habitat designated or proposed for the action area; and (3) the biological assessment has been supplemented with any relevant changes in information.

Condition (1) has been expanded to allow incorporation by reference if the proposed action involves similar impacts (rather than no new impacts). The term "or administrative unit" has been deleted as it is substantially the same as "geographic area." The Service adds "for the action area" at the end of condition (2) to clarify the scope of the certification. Finally, condition (3) is changed to allow Federal agencies to incorporate a former biological assessment by reference while supplementing it with any relevant changes in information. This change clarifies the intent behind this paragraph.

Paragraph (h) of §402.12, which cross-references permit requirements under the Act that may apply to the preparation of a biological assessment, is adopted as proposed in §402.12(b)(4)(i). The Service believes that the references in the rule are adequate to alert Federal agencies and/or designated non-Federal representatives of the need to consider applicable permit requirements, rather than include the appropriate section 10 permit requirements in these regulations, as suggested by one commenter. Certain field work might involve the take (*i.e.*, harassment, harm, etc.) of listed species which, absent a permit, would violate sections 9 or 4(d) of the Act. To avoid possible violations, the Federal agency or non-Federal representative should apply for and obtain a section 10 permit for such field work. Those individuals carrying out field studies or other research without a permit during the section 7 consultation process are subject to the prohibitions of the Act and other applicable wildlife laws. The Service emphasizes that permits should be obtained if takings of any listed species are anticipated.

Paragraph (i) of §402.12 specifies the time period for completing a biological assessment and sets out the requirements for any needed extension. This paragraph is taken substantially from §402.12(b)(6) of the proposed rule.

Two commenters asked that the rule require written notices of all extensions, regardless of whether an applicant is involved. A written notice from the Federal agency to the applicant is required if an extension is agreed upon between the Service and the Federal agency, and such written notice must be provided by the Federal agency prior to

the expiration of the 180-day time period. However, the Service declines to require a written notice if an applicant is not involved in the consultation, because responsibility for the preparation and completion of the biological assessment rests with the Federal agency. The Service will defer to the needs and judgment of the Federal agency which can document the extension in its administrative record.

Another commenter asked that the Service explain that the 180-day time period begins on the date of receipt of the species list (or the date of receipt of the Director's concurrence with the Federal agency species list). This change has been made since it clarifies when the time period begins and is consistent with the intent of this paragraph.

As noted above, if an applicant is involved, the 180-day period may not be extended unless the agency provides the applicant, before the close of the 180-day period, with a written statement setting forth the estimated length of the proposed extension and the reasons why an extension is necessary. The applicant has no remedy to expedite the preparation of the biological assessment under section 7(c) of the Act. Thus, the 180-day time period is subject to an indefinite extension at the Federal agency's prerogative. The Service lacks statutory authority to impose an appeal process to review extensions, as requested by two commenters.

Paragraph (j) of §402.12, which requires the submission of completed biological assessments to the Director for review, is adopted from proposed §402.12(b)(4)(iii). In response to two comments, the Director will make a written response within 30 days after receiving the complete assessment as to whether or not the Service concurs with the findings in the assessment. This change provides Federal agencies with a written record acknowledging the Service's receipt of the biological assessment and indicating the results of the Service's review.

A new sentence is added to this paragraph to clarify that the Federal agency may initiate formal consultation concurrently with the submission of the assessment to the Director.

In response to one comment, the Service declines to substitute "Service" for "Director" in this paragraph. It is important that the Director or his authorized representative directly receive the biological assessment for review so that a timely review can be facilitated.

Paragraph (k) of §402.12, governing the use of a completed biological assessment, is derived from §402.12(b)(7) of the proposed rule. Once the biological assessment has been completed, the Federal agency must consider whether formal consultation should be initiated or if a conference is necessary. Three commenters noted that a written notice of concurrence should be issued by the Director if the Service agrees with the Federal agency's finding that its action is not likely to adversely affect listed species or critical habitat (*i.e.*, the Service concurs in writing that formal consultation is not needed). This comment has been accommodated by appropriate changes to paragraphs (j) and (k).

The proposed §402.12(b)(5), "Assistance from other sources," has not been included in the biological assessment section of the final rules. The substance of this paragraph has been included in the final §402.08 dealing with designated non-Federal representatives. The first two sentences have been deleted since a Federal agency may obtain assistance from any source to aid in the preparation of a biological assessment (or other aspect of consultation), and it does not need to be authorized in these regulations. One commenter suggested that the Service be included as a source of information; however, assistance from the Service is already included in appropriate sections of the regulations.

Section 402.13 Informal Consultation.

Informal consultation is an optional procedure that includes all contacts between the Service and the Federal agency or the designated non-Federal representative prior to formal consultation, if required. It is designed primarily to except from the formal consultation process those proposed actions which, upon further informal review, are found not likely to adversely affect a listed species or critical habitat. If the Service concurs with such a determination, formal consultation is not required. The final rule is adopted largely by combining proposed §§ 402.12(a), 402.15(c), and 402.15(i)(1), into one composite statement of the purpose and scope of informal consultation.

Several commenters disagreed on the scope of informal consultation. One commenter felt that informal consultation should include all dialogue between the Service, the Federal agency, and any designated non-Federal representative in determining whether formal consultation is required. Another commenter recommended that informal consultation be available if listed species are found in the action area. The Service believes that informal consultation encompasses all of these communications between the Service, the Federal agency, and the designated non-Federal representative, as well as others. The Service is available for informal consultation at any time; the decision on whether to seek informal consultation is that of the Federal agency. The Service agrees that, if requested as a part of informal consultation, it should participate in NEPA scoping meetings.

The Service declines to specify uniform levels of contact that must be followed in conducting informal consultations. Existing relationships between the Service's field or regional offices and particular Federal agencies mandate maximum flexibility. The present system is working well and efficiently addresses the needs of other Federal agencies, and it is therefore retained.

Because informal consultation is an optional process that is under the control of the Federal agency as to its initiation and duration, the Service declines to require notices of initiation and/or termination. Such a step would merely place paperwork burdens on the Federal agency in an otherwise voluntary process.

As noted in §402.12; biological assessments are required for major construction activities. To clarify a procedural point, the Service notes that the biological assessment process may be conducted simultaneously with informal consultation if desired by the Federal agency, or the Federal agency may choose to undertake the biological assessment without any informal consultation. Whether or not a biological assessment is required, the Federal agency may choose to enter into informal consultation.

In response to many comments, the Service has made numerous adjustments throughout these regulations to eliminate references to informal consultation as a prerequisite to formal consultation. The Service agrees that such a process would not be workable, both as a result of limited consultation resources and the need to respect Federal agency program discretion. As previously noted, the proposed rule required formal consultation if the action "may adversely affect" listed species or critical habitat. "Beneficial" actions were excused from formal consultation if the Service concurred during the mandatory informal consultation. Since informal consultation has been made strictly an optional process in this final rule, the Service retains, from the 1978 rule, the "may affect" trigger for formal consultation in §402.14 of the final rule.

Under this final rule, if a Federal agency determines that its action "may affect" listed species or critical habitat, then formal consultation is required unless an exception applies. One exception is that a Federal agency may, through informal consultation, utilize the expertise of the Service to evaluate the agency's assessment of potential effects or to suggest modifications to the action to avoid potential adverse effects. If, as a result of informal consultation, the Federal agency determines, and the Service concurs, that the action (or modified action) is "not likely to adversely affect" listed species or critical habitat, then formal consultation is not required. The consultation process would terminate with the written concurrence of the Service. Therefore, through this informal consultation process, those activities which are found to have beneficial, discountable, or insignificant effects upon listed species or their critical habitats could be deemed to be in compliance with section 7(a)(2) without formal consultation. If a "not likely to adversely affect" determination cannot be made during informal consultation, then formal consultation is required for those Federal actions that "may affect" listed species or their critical habitat.

In short, the final rule retains the general requirement for formal consultation if the Federal agency determines that its action "may affect" listed species or critical habitat. The Federal agency may, however, through voluntary informal consultation with the Service, forego formal consultation and promptly implement actions that the agency and the Service agree are not likely to adversely affect listed species or critical habitat. The Service finds that this reformulation of the consultation process is not significantly different from the current practice, except that, as a result of informal consultation, biological opinions will no longer be required for actions that "are not likely to adversely affect" listed species or critical habitat.

The Service could not accommodate all concerns expressed on this issue. Two commenters contended that the "may adversely affect" standard for initiating formal consultation yielded too much discretion to action agencies. They stated that such a threshold would shift the benefit of the doubt from one in favor of the listed species to one in favor of the Federal agency's action. Noting the Service's expertise on wildlife issues, the commenter urged the Service to reverse this shift. As noted above, the Service did not intend to reverse the burden of proof with the focus on "adverse effects." The goal is to reduce procedural barriers for actions which the Service believes are not likely to have an adverse effect, while retaining full protection for listed species or critical habitat. The changes noted above address these commenters' concern. However, other commenters who suggested a shift in the burden of proof cannot be accommodated. The commenters that urged a "would adversely affect" standard for triggering formal consultation, a standard that might be interpreted as requiring a showing of effects that destroy or adversely modify critical habitat or are likely to jeopardize the continued existence of listed species, are requesting a trigger for formal consultation that the Service believes is too close to the "jeopardy" standard of section 7(a)(2). The threshold for formal consultation must be set sufficiently low to allow Federal agencies to satisfy their duty to "insure" under section 7(a)(2). Therefore, the burden is on the Federal agency to show the absence of likely, adverse effects to listed species or critical habitat as a result of its proposed action in order to be excepted from the formal consultation obligation.

The Service believes that informal consultation is extremely important and may resolve potential conflicts (adverse effects) and eliminate the need for formal consultation. Through informal consultation, the Service can work with the Federal agency and any applicant and suggest modifications to the action to reduce or eliminate adverse effects. If a Federal agency modifies its action so that the action is not likely to adversely affect listed species or critical habitat, then formal consultation is not required.

Section 402.14 Formal Consultation.

These regulations require Federal agencies to review their actions to determine whether they "may affect" listed species or critical habitat. Formal consultation procedures must be initiated if such a situation exists, unless, with the written concurrence of the Service, the Federal agency determines through informal consultation and/or through the biological assessment process that its action is not likely to adversely affect listed species or critical habitat. As noted above in regard to § 402.13, the final rule adopts the "may affect" standard of the 1978 rule, with a special provision allowing actions "not likely to adversely affect" to by-pass the formal consultation process as a result of informal consultation with the Service.

Paragraph (a) of § 402.14 sets out the requirements for formal consultation. This paragraph is a composite of paragraphs (a) and (k) of proposed § 402.15. Paragraph (b), which sets out the exceptions to the initiation requirement of (a), was taken primarily from proposed §§ 402.12(b)(7) and 402.15 (b) and (c).

The Service declines to substitute "may" for "shall" in describing the Federal agency's responsibilities in paragraph (a), as requested by one commenter. Federal agencies have an obligation under section 7(a)(2) of the Act to determine whether their actions may affect listed species and whether formal consultation is required under these regulations. However, the Service does not intend to mandate the timing of this review, which is solely at the discretion of the Federal agency. Early review of its actions is to the advantage of the Federal agency so that compliance with section 7 can be attained without undue delays to its action.

Paragraph (a) also includes a provision for the Director to request a Federal agency to enter into consultation. Two commenters asked that the final rule empower the Director to require a Federal agency to consult. Although the Service will, when appropriate, request consultation on particular Federal actions, it lacks the authority to require the initiation of consultation. The determination of possible effects is the Federal agency's responsibility. The Federal agency has the ultimate duty to ensure that its actions are not likely to jeopardize listed species or adversely modify critical habitat. The Federal agency makes the final decision on whether consultation is required, and it likewise bears the risk of an erroneous decision.

The last sentence of proposed § 402.15(a), dealing with Service assistance to Federal agencies, has been deleted as it is more appropriately addressed in the preamble. The Federal agency may obtain information and advice from the Service, but this is a supplement to, and not a substitute for, formal consultation. The Service believes that there should be a continuous dialogue between the Service and the Federal agency involving the exchange of information and assistance as part of the formal consultation.

Unless a Federal agency chooses to avail itself of the exceptions in paragraph (b), it must initiate formal consultation if its proposed action "may affect" listed species or critical habitat. Any possible effect, whether beneficial, benign, adverse, or of an undetermined character, triggers the formal consultation requirement, as suggested

by one commenter. However, although informal consultation is not required, a Federal agency may use that process and/or the biological assessment process to remove an action that "is not likely to adversely affect" listed species or critical habitat from the formal consultation requirement.

Proposed paragraph (c), a "no adverse effect" exception, was attacked as weakening the Act. One commenter remarked that this procedure unrealistically allows Federal agencies to determine the presence of a "detrimental effect," through informal consultation, when the precise objective of formal consultation is to reach that same goal. The Service does not agree, because formal consultation is conducted to determine if an action is likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat. Adverse effects may exist without constituting jeopardy. However, the Service has changed the trigger for formal consultation to "may affect" with certain exceptions contained in paragraph (b).

The exceptions in paragraph (b) are derived from the "will not adversely affect" exception in proposed §402.15(c) and from the confirmation of the preliminary biological opinion in proposed §402.15(b). The first exception is modified to "not likely to adversely affect" to make the biological assessment provisions compatible with the formal consultation provisions. Under section 7(c) of the Act, a biological assessment is completed to facilitate compliance with the consultation provisions of section 7(a)(2) by identifying whether any species or critical habitat is "likely to be affected." If the Federal agency determines, with Service concurrence, that its action is not likely to adversely affect any listed species or critical habitat, there is no need for formal consultation.

Imposing the time delays and information responsibilities of formal consultation on such actions would not provide any additional protection to listed species or critical habitat and may discourage interagency cooperation. Regulatory flexibility is appropriate here to eliminate undue burdens. By requiring the Service's "written concurrence" with a "not likely to adversely affect" finding as a prerequisite to invoking the exception to formal consultation, the Service believes it has retained adequate review authority through informal consultation. If the information made available during informal consultation is not sufficient to make this determination, formal consultation is required. The case of *Romero-Barcelo* v. *Brown*, 643 F.2d 835 (1st Cir. 1981), *rev'd on other grounds sub nom. Weinberger* v. *Romero-Barcelo*, 456 U.S. 305 (1982), does not preclude this change. That decision interpreted the 1978 rule but did not set a minimum threshold for initiation of formal consultation under the Act. Paragraphs (a) and (b), as adopted, are totally within the statutory authority of the Service.

The other exception to the general formal consultation requirement is the confirmation of a preliminary biological opinion as the final biological opinion. If early consultation takes place, the Service will issue a preliminary biological opinion. When the prospective applicant applies for a Federal permit or license, the Federal agency may request that the Service confirm the preliminary biological opinion as the final biological opinion that would have been issued after formal consultation. If the Service reviews the proposed action and finds no significant changes in the action as planned and no significant changes in the information used during early consultation, such a confirmation will be issued. Consultation is required if the preliminary biological opinion is not confirmed.

Paragraph (c) of §402.14 specifies the required contents of a request for formal consultation. This paragraph is adopted substantially from proposed §§402.12(b)(7) and 402.15(d).

According to one commenter, the information requirements of paragraph (c), which apply to all actions involved in formal consultation, lack statutory authority. The Service cites the obligation to use the "best scientific and commercial data available" and the overall responsibility to consult in good faith under section 7(a)(2) as ample authority for the information requirements. Proposed item (vi), requiring a list of Federal agencies that have jurisdiction in the action area and how they may be affected, is too broad since much of this information would be unrelated to the consultation. Other Federal actions that are interrelated or interdependent would be discussed along with the effects of the action. Therefore, this item is not included in the final rule. The remaining items are essential in determining the parameters of the action, the extent, duration, and severity of its impacts, and the effects of other actions in the action area. The Service retains these essential information requirements, although it has noted under subparagraph (5) that only "relevant" reports, including environmental impact statements, etc., need be supplied, because consultations will in most cases be completed prior to the production of final NEPA documentation for the subject action.

The concluding sentences of paragraph (c) permit Federal agencies, subject to the Director's approval, to tailor their requests for consultation to a particular segment of a comprehensive plan, so long as the effects of the action as a whole are considered. To clarify this passage, as requested by one commenter, the Service uses the example of the management, pursuant to a comprehensive plan, of a National Wildlife Refuge that is inhabited by a listed species. Section 7 consultation may be undertaken on a segment of that management program, such as big-game hunting, and a biological opinion will be issued on that phase of the program only. However, in formulating its biological opinion, the Service must consider the effects, including indirect effects, of the action as a whole, and cumulative effects of unrelated management programs in reaching the conclusion of "jeopardy" or "no jeopardy." The concluding passage of paragraph (c) illustrates the flexibility inherent in the formal consultation process and the care with which the protections of section 7 are preserved.

Paragraph (d) of §402.14 repeats the required information standard of section 7(a)(2): "best scientific and commercial data available." This paragraph is adopted essentially without change from proposed §402.15(d)(2), except that, pursuant to public comment, the Service changed "biological information" to "scientific and commercial data" to bring the language of the regulation in line with the Act. One commenter suggested that the phrase "or which can be developed during the consultation process" be removed from this paragraph. The Service has modified the wording to state that the information referred to in this paragraph is information that can be obtained during the consultation. We believe that information could become available at any time during the consultation, and such information should be submitted to the Service for its consideration. The legislative history of the 1979 Amendments supports this provision. H.R. Conf. Rep. No. 697, 96th Cong., 1st Sess. 12 (1979). The Service is satisfied that this paragraph adequately mandates the use of the best available scientific and commercial data, requires Federal agencies to supply this data at any time during formal consultation, and recognizes that this information requirement is a Federal agency

responsibility—not an obligation of the Service.

Paragraph (d) of § 402.14 also adopts a portion of § 402.15(d)(3) of the proposed rule that requires the Federal agency to provide any applicant with the opportunity to participate in formal consultations, including submitting information for consideration during the consultation. The remainder of proposed § 402.15(d)(3) was deleted because it duplicated other parts of the final rule.

Paragraph (e) of § 402.14 establishes the time period for conducting formal consultations and explains the process for extending the consultation period. The paragraph is adopted substantially as proposed in § 402.15(e), with certain technical, clarifying amendments.

The Amendments changed the timing requirement on the conclusion of formal consultation from the 60 days originally established by the 1978 rule to a maximum of 90 days or to such time periods as discussed below. If an applicant is involved, the Service and the Federal agency may mutually agree to extend consultation for up to 60 additional days without the consent of the applicant, provided that the Service submits to the applicant, before the close of the initial 90-day period a written statement setting forth (1) the reasons why a longer period is required, (2) the information that is required to complete the consultation, and (3) the estimated date on which the consultation will be completed. A consultation involving an applicant cannot be extended for more than 60 days without the consent of the applicant. The biological opinion must be delivered to the Federal agency and any applicant promptly after the conclusion of formal consultation (within 45 days).

One commenter suggested that a provision be added that would require the Service to issue a notice concluding formal consultation with a finding that it has sufficient information to prepare a biological opinion. The Service declines to adopt this comment. At the end of the 90-day period (unless extended), the parties to the consultation realize that the Service has but 45 days to deliver its biological opinion to the Federal agency and any applicant. A mandatory notice of "sufficient information" might be, in some cases, misleading by creating the impression that additional information or studies may not be advisable. The Service must develop its biological opinion based upon the best scientific and commercial data available regardless of the "sufficiency" of that data. Therefore, the suggested change does not accurately reflect the legal framework within which the Service must operate.

The Service has defined the statutory directive to issue biological opinions "promptly after" the conclusion of formal consultation as requiring the delivery of a biological opinion to the Federal agency and any applicant within 45 days. Several commenters agreed with this stipulated deadline as long as the applicant retains some control over extensions. Other commenters felt that the 45-day period was excessive, and they argued that the opinion drafting period should either be worked out with mutually-agreeable extensions or the opinion should be issued by the end of the consultation period. The Service retains the 45-day drafting period as consistent with the statutory requirement and as a necessary time period to further refine biological opinions after the conclusion of formal consultation.

One sentence has been added to paragraph (e) to acknowledge the ability of the Service and the Federal agency, where no applicant is involved, to extend consultation for a mutually-agreeable time period. This clarification satisfies the request of one commenter.

Paragraph (f) of § 402.14, which governs Service requests for additional information, is adopted from § 402.15(j)(1) of the proposed rule. The Service declines to rename this paragraph "extension of consultation" because that topic is generally covered in paragraph (e).

In some cases, the Service may determine that additional information would enhance the formulation of its biological opinion. To cover this situation, the final rule adopts the procedures discussed by Congress in the legislative history of the 1979 Amendments. S. Conf. Rep. No. 697, 96th Cong., 1st Sess. 12 (1979). When additional data is believed to be advantageous, the Service will request an extension of formal consultation. When the Service requests such an extension, it will identify the types of additional data sought for assisting consultation. The Service will, to the extent practicable, and within existing budgetary and personnel restrictions, provide assistance in planning studies, furnishing relevant data, and providing recommendations that may be necessary to obtain the additional data. The responsibility for conducting and funding any studies, however, belongs to the Federal agencies or the applicant and not to the Service.

The comments received on this paragraph covered a wide spectrum of opinion as to the breadth of the Service's authority to request additional data. Some commenters questioned the statutory authority of the Service under this provision, and they erroneously interpreted the Service's ability to *request* additional data as the authority to *require* an extension of formal consultation to obtain such data. Their position was that additional data was not a valid reason for seeking an extension of formal consultation and that additional data should only be sought when obtaining it would not delay the consultation and when the Service is willing to fund the studies. Another commenter went further, suggesting that the request for additional data be treated as an extraordinary measure that should be invoked "reluctantly and only on rare occasions." The commenter said that the Service should affirmatively state that existing data is presumed to be adequate and that the Service bears the burden of demonstrating inadequacy before seeking additional data.

On the other end of the spectrum, several commenters faulted the Service for not requiring an extension so that additional data could be obtained under this paragraph. Citing the Federal agency's statutory duty to use the "best scientific and commercial data available" and the decision in *Roosevelt Campobello International Park Commission* v. *EPA*, 684 F.2d 1041 (1st Cir. 1982) ("*Pittston* case"), these commenters noted that Federal agencies are required by section 7(a)(2) to do "all that [is] practicable" to develop information for the consultation. *Pittston* case, *supra*. According to the commenters, the proposed rule gave too much discretion to Federal agencies in controlling the information used in the consultation process.

The Service adopts the proposed rule because it recognizes the need for an opportunity to request additional data while deferring to the Congressional intent that consultation have a definite end point. Additional data may be requested by the Service, but the Service is not relieved of its duty to issue a biological opinion unless appropriate time extensions are obtained under paragraph (e).

However, Federal agencies and applicants are cautioned that they bear the burden under section 7(a)(2) to show that they have obtained the best available scientific and commercial data. This is not the Service's burden or obligation, but the Service does have the responsibility to alert the Federal agency and any applicant of areas where additional data would provide a better information base from which to

formulate a biological opinion. This advice from the Service is intended to help the Federal agency to better satisfy its duty to *insure* that its action is not likely to jeopardize listed species or adversely modify critical habitat.

A Service request for additional data will not be used as a vehicle for burdening applicants with unnecessary studies and inordinate delays, as feared by one commenter. As in the *Pittston* case, these requests will be limited to readily obtainable data that would assist the Service in formulating its biological opinion. In paragraph (f), as in *Pittston*, a distinction must be made between requests for special research projects and requests for routine, customary data collection activities. Moreover, paragraph (f) does not take the final decision regarding the acquisition of additional data away from the Federal agency. The agency still has the discretion to reject the Service's request for additional data provided it is not arbitrary or capricious in doing so. The paragraph has been clarified to state that the Federal agency, when collecting additional data, shall do so to the extent practicable and within the timeframe of the agreed upon extension.

The Service, in requesting additional data, will not comment as to the overall adequacy of the Federal agency's data. It is the agency's burden to obtain credible data. The Service's request for additional data, just as the Federal agency's inability to complete any agreed upon collection of data, should not be interpreted as evidence that the Federal agency has failed to meet the information standard of section 7(a)(2); it would merely represent the Service's belief that the additional data would improve the consultation data base so that it could issue the best biological opinion possible. The Service, therefore, has added language to the final rule to clarify this provision.

As discussed above, if an extension is not agreed to in accordance with paragraph (e), the Service shall issue a biological opinion based on the best scientific and commercial data made available during the consultation. The Conference Report to the 1979 Amendments states that in this situation, the Federal agency has a continuing responsibility to make a reasonable effort to develop additional data. H.R. Conf. Rep. No. 697, 96th Cong., 2d Sess. 12 (1979). By initiating informal consultation with the Service at an early stage of the development of a proposed action, the Federal agency would, in most cases, minimize the need to request an extension of formal consultation because of a lack of data.

In formulating its biological opinion, the Service must provide the "benefit of the doubt" to the species concerned, H.R. Conf. Rep. No. 697, *supra*, at 12. In addition, a biological opinion must be developed within the consultation timeframe based upon the best scientific and commercial data available. Though requested by several commenters, the Service is not authorized to condition its "no jeopardy" opinions with "safeguards" or to issue "may jeopardize" opinions in retaliation for an agency refusal to extend consultation or to develop additional data.

The Service was requested to publish availability notices for biological opinions to facilitate public participation in the conservation of listed species. For the reasons noted previously in response to a general comment, the Service declines to impose such a requirement on itself as an amendment to paragraph (f).

Paragraph (g) of § 402.14, which sets out the Service's responsibilities during formal consultation, is adopted from proposed § 402.15(f) with only minor changes to clarify the Service's responsibilities. The public comments concerning paragraph (g) focused on the fifth item: the responsibility to discuss the availability of reasonable and prudent alternatives. The Service is committed to working closely with Federal agencies and any applicants in the development of reasonable and prudent alternatives. However, the Service is unable to agree that a draft reasonable and prudent alternative should be excluded from the biological opinion if the Federal agency disagrees as to its reasonableness, as suggested by one commenter. The Service will, in most cases, defer to the Federal agency's expertise and judgment as to the feasibility of an alternative. Nevertheless, in those instances where the Service disagrees with a Federal agency's assessment of the reasonableness of its alternatives, the Service must reserve the right to include those alternatives in the biological opinion if it determines that they are "reasonable and prudent" according to the standards set out in the definition in § 402.02; the Service cannot abdicate its ultimate duty to formulate these alternatives by giving Federal agencies control over the content of a biological opinion.

Paragraph (g) provides for Federal agency and applicant review of the basis for any finding contained in draft biological opinions, including the availability of reasonable and prudent alternatives. Four commenters requested that the final rule clarify whether an applicant was entitled to receive a copy of the draft biological opinion. The Service believes that the applicant should participate in the review and should receive a copy of the draft opinion from the Federal agency. The final rule includes this provision.

The release of draft opinions to Federal agencies and any applicants (through the Federal agency) facilitates a more meaningful exchange of information. Review of draft opinions may result in the development and submission of additional data, and the preparation of more thorough biological opinions. Two commenters opposed the release of draft biological opinions. Although they were supportive of open communication and mediation between the Service and the Federal agency during the consultation time period, the commenters opposed Federal agency review of draft opinions because agencies could bring pressure on the Service to modify a particular reasonable and prudent alternative or to convert the opinion's conclusion from "jeopardy" to "no jeopardy." If there were any discussions needed regarding the reasonable and prudent alternatives, noted the commenters, this could be done in "further discussion" after the issuance of the biological opinion. The Service disagrees that Federal agency review of draft biological opinions will result in "rewritten" biological opinions, unless valid biological reasons mandate a change. Federal agency review of draft opinions helps ensure the technical accuracy of the opinion, and may save time and resources by resolving these issues early. The Service believes that the availability of draft biological opinions is a meaningful process and has retained it in the final rule. As noted previously in the "Definitions" section, "further discussion" has been deleted from this rule. Thus, through the discussions between the Service and the Federal agency and any applicant during formal consultation and the provision to review draft biological opinions, the exchange of information for the development of reasonable and prudent alternatives is sufficient.

The proposed rule stated that the 45-day deadline for delivery of the final biological opinion would be suspended while the Federal agency retained the draft opinion. Several commenters complained that such a suspension would violate the statutory deadlines for concluding formal consultation and that the applicant would be powerless to force an end to the consultation. Although the proposed rule provided

that, "[i]f the draft biological opinion is not returned to the Service within a reasonable period of time, the Service will issue a final biological opinion," the Service agrees that the meaning of "a reasonable period of time" requires clarification. Therefore, to accommodate these comments, the Service now requires the Federal agency to secure the applicant's written consent to an extension for a specified time period if the 45-day deadline is to be suspended while the draft opinion is under review. If no extension is agreed to, the biological opinion will be issued within 45 days of the conclusion of formal consultation.

Another commenter suggested that the Service be required to deliver its biological opinion within the Federal agency's NEPA timeframe so that the biological opinion can be included without delaying the release of the agency's NEPA document. The Service will attempt to coordinate all environmental reviews with the consultation. However, special timing problems under other Federal statutes, or failure to enter into the consultation process early in the planning stage of an action, is not a justification for altering the required timeframe established under the Act. If a particular Federal agency needs special procedures to handle its consultation responsibilities, the Service urges the development of counterpart regulations under §402.04.

Paragraph (g) has also been modified to reflect that the Service, in formulating its biological opinion, any reasonable and prudent alternatives, and any reasonable and prudent measures, will use the best scientific and commercial data available and will give appropriate consideration to any beneficial actions taken by the Federal agency or applicant including any actions taken prior to the initiation of consultation.

Paragraph (h) of §402.14, which deals with the contents of a biological opinion, is adopted with minor, technical corrections from proposed §402.15 (g)-(h). The final rule distinguishes that information or material which will be included in a biological opinion from that which will be provided with a biological opinion.

The biological opinion will include: (1) a summary of the information on which the opinion is based; (2) a detailed discussion of the effects of the action on listed species or critical habitat; and (3) the Service's opinion as to whether the action is likely to jeopardize the continued existence of a listed species or result in the destruction or adverse modification of critical habitat. The biological opinion will conclude that either: (1) the action is not likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat (a "no jeopardy" biological opinion), or (2) the action is likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat (a "jeopardy" biological opinion).

If a "jeopardy" biological opinion is issued, the Service must identify and include reasonable and prudent alternatives, if any, that will avoid jeopardy and that the Federal agency or applicant can implement. If the Service is unable to develop reasonable and prudent alternatives, it will indicate that, to the best of its knowledge, there are no such alternatives that would satisfy the standard of section 7(a)(2).

Paragragh (i) of §402.14, which governs incidental taking under section 7(b)(4) of the Act, is adopted essentially as proposed in §402.19. This paragraph is included in the formal consultation section of the final rule because of the direct relationship between final biological opinions and incidental take statements.

The 1982 Amendments changed section 7(b) to include provisions concerning incidental taking of species. The new provisions included in sections 7(b)(4) and 7(o)(2) of the Act are designed to resolve the situation where a Federal agency or an applicant has been advised, through a biological opinion, that the proposed action or the adoption of the reasonable and prudent alternative(s), will not violate section 7(a)(2) of the Act, but the proposed action (or adopted alternative) will result in taking individuals of a listed species incidental to the action. The new provision states that, if the action complies with specified terms and conditions, the resulting incidental take will not be a violation of any "taking" prohibitions established by section 4(d) or 9(a)(1) of the Act.

As noted in the public comments, the availability of an "incidental" taking exemption through the section 7 consultation process is a welcome clarification made by the 1982 Amendments. However, many commenters requested additional guidance on this subject, and several felt that the proposed rule was cumbersome and burdensome. The Service believes that the following discussion will clarify the incidental take provision and explain the incentives for compliance with sections 7(a)(2) and 7(b)(4) of the Act.

If an agency action receives a "no jeopardy" biological opinion, or if the Federal agency adopts any reasonable and prudent alternative provided in a "jeopardy" biological opinion, then the action may proceed in compliance with section 7. An incidental take statement will be provided with the biological opinion when the activity may incidentally take individuals of a listed species but not so many as to jeopardize their continued existence. If the action proceeds in compliance with the terms and conditions of the incidental take statement, then any resulting incidental takings are exempt from the prohibitions of section 4(d) or 9 of the Act. No permit is required of the Federal agency or any applicant in carrying out the action, as one commenter contended. The biological opinion, plus the incidental take statement, operate as an exemption under section 7(o)(2) of the Act. However, this exemption is limited to actions taken by the Federal agency or applicant that comply with the terms and conditions specified in the incidental take statement. Compliance with these terms and conditions is mandatory to qualify for the exemption from section 4(d) or 9 of the Act. "Actions that are not in compliance with the specified measures . . . remain subject to the prohibition against takings that is contained in section 9." S. Rep. No. 418, 97th Cong., 2d Sess. 21 (1982). Therefore, the Service cannot make these terms discretionary, as urged by one commenter.

Paragraph (i)(1) states that, where incidental takings may occur, the Service will provide with the biological opinion to the Federal agency and applicant a written statement that: (i) specifies the impact, *i.e.*, amount or extent, of such anticipated incidental take of the species that does not violate section 7(a)(2), (ii) specifies those reasonable and prudent measures necessary or appropriate to minimize such impact, (iii) sets forth the terms and conditions, including, but not limited to, reporting requirements, that must be complied with by the Federal agency or any applicant in order to implement the reasonable and prudent measures specified under (ii) above, and (iv) specifies the procedures to be used to handle or dispose of any individuals of a species actually taken. Several comments were received on these elements of the incidental take statement.

Because, in some cases, exact numerical limits on the amount of permissible incidental taking will be difficult to determine, the Service may, in accordance with (i)(1)(i), specify the extent of anticipated take that will not violate section 7(a)(2) of the Act. The impact of a particular action may only

be predictable in terms of the extent of land or marine area that may be affected. Precise numbers of individuals that may be taken are preferable to descriptions of the extent of disruption and will be provided when they can be computed. However, the Service reserves the flexibility in the rule so that the most appropriate standard for an individual consultation can be used. The Service declines to endorse the use of numerical amounts in all cases over the use of descriptions of extent, because for some species loss of habitat resulting in death or injury to individuals may be more deleterious than the direct loss of a certain number of individuals. Likewise, the Service declines to incorporate into the final rule the comment that would focus take levels on population numbers and recovery plan guidelines, if available. One commenter suggested that two figures or levels be specified: "the expected and the acceptable amount or extent" of take. This approach offers the benefit of giving a "caution" signal to Federal agencies or applicants as they approach a possible problem with the incidental takings resulting from the action. Steps could be taken to correct the course of the action before the threshold of reinitiation (level of maximum anticipated take) is exceeded. The Service recognizes the merit of this approach but does not require that it be followed under the final rule because it may not be appropriate for all Federal actions.

Paragraph (i)(1)(ii) states that the incidental take statement shall specify those reasonable and prudent measures necessary to minimize the level of incidental take. For the reasons discussed under the definition of reasonable and prudent measures, the Service has added a new paragraph (i)(2) to the final rule to clarify that reasonable and prudent measures may only involve minor changes that do not alter the basic design, location, duration, or timing of the action. Should the Service believe that the way to minimize the incidental takings is through research, an explanation of how such research will accomplish this will be included. Any research-related reasonable and prudent measure shall be subject to the limitations in paragraph (i)(2).

Paragraph (i)(1)(iii) provides that reporting requirements must be included in the terms and conditions of an incidental take statement. As explained in paragraph (i)(3), these reporting requirements will be tailored to the nature of the particular Federal action and will, to the extent possible, be limited to existing reporting requirements.

Under 50 CFR 13.45 (FWS) and 222.23(d) (NMFS), there are provisions concerning reporting requirements for any taking of threatened or endangered species. These reporting requirements are not limited to annual reports, and may vary in accordance with the particular needs of the species as set forth in the incidental take statement. Congress did not prohibit the imposition of new reporting requirements, contrary to the assertion of one commenter.

Another commenter said that the disposal procedures in item (i)(1)(iv) should refer to "specimens" taken, not to species taken. The Service has accommodated the commenter's concern by inserting "individuals of a species" in item (iv).

Paragraph (i)(4) requires the Federal agency or the applicant to immediately request reinitiation of formal consultation if the specified amount or extent of incidental take is exceeded. One commenter argued that the Service is allowing the "jeopardy" ceiling to be exceeded in (i)(4). The Service disagrees; however, the Service agrees that the amount or extent of take should not be set at the threshold of likely jeopardy. If the establishment of such a high taking level were necessary to cover all impacts of a proposed action, it is questionable whether the issuance of a "no jeopardy" opinion is appropriate. It is not expected that the level of incidental take anticipated for most "no jeopardy" actions would come close to the section 7(a)(2) barrier.

Congress recognized this in the House Report to the 1982 Amendments:

> If the specified impact on the species is exceeded, the Committee expects that the Federal agency or permittee or licensee will immediately reinitiate consultation since the level of taking exceeds the impact specified in the initial section 7(b)(4) statement. In the interim period between the initiation and completion of the new consultation, the Committee would not expect the Federal agency or permittee or licensee to cease all operations unless it was clear that the impact of the additional taking would cause an irreversible and adverse impact on the species.

H.R. Rep. No. 567, 97th Cong., 2d Sess. 27 (1982). Exceeding the level of anticipated taking does not, by itself, require the stopping of an ongoing action during reinitiation of consultation. The Federal agency must make this ultimate decision, taking into consideration the prohibitions of sections 7(a)(2) and 7(d). Further, the Service will enforce the taking prohibitions of section 4(d) or 9 if the continuation of an action, after the anticipated level of incidental take has been reached, results in additional takings of listed species.

This provision for incidental take in no way affects a Federal agency's responsibility under section 7(a)(2) to ensure that its action is not likely to jeopardize the continued existence of a listed species or result in the destruction or adverse modification of critical habitat. The Service agrees with one commenter that the basis for the conclusion that incidental take will not violate section 7(a)(2) should be included with the biological opinion.

Paragraph (j) specifies that the Service may provide any conservation recommendations with the biological opinion. Several commenters objected to the inclusion of conservation recommendations in the biological opinion, and questioned whether these recommendations were to have binding force. The comment submitted by the House Committee summarized these concerns:

> While the proposed regulations conform to the statute regarding the recommending of "reasonable and prudent alternatives" only where jeopardy is found, they also inject a totally new concept referred to as "conservation recommendations." Although we do not argue with the appropriateness of wildlife agencies recommending measures that could be taken to lessen a project's impact on endangered or threatened species, it should be made clear in the regulations that failure to abide by these recommendations does not result in a violation of section 7(a)(2) of the Act. In addition, while the language of section 7(a)(1) does direct all Federal agencies to "utilize their authorities in furtherance of the purposes of [the Act] by carrying out programs for the conservation of endangered species and threatened species", we do not believe that it was intended that section 7(a)(1) require developmental agency actions to be treated as conservation programs for endangered or threatened species. We also do not believe that all of the conservation recommendations of the Secretary have to be followed for this requirement to be met. Such an interpretation would render the much debated provisions of section 7(a)(2) redundant and essentially meaningless and bring about endless litigation.
>
> Accordingly, we suggest that any conservation recommendations be transmitted to action agencies separate from biological opinions and that the regulations state plainly that failure to accept or implement the recommendations does not constitute a violation of section 7 of the Act.

The Service agrees with the Committee's comments and has amended the proposed rule accordingly. Discretionary conservation recommendations will be provided with the biological opinion as a separate statement rather than as an integral part

of the opinion. In this rule, conservation recommendations [402.14(j)] are discussed separately from biological opinions [402.14(h)]. A sentence has been added at the conclusion of paragraph (j) to emphasize the advisory, non-binding nature of conservation recommendations.

Paragraph (k) of §402.14, which deals with incremental steps, is adopted with minor, technical changes from proposed §402.15(j)(2). Paragraph (k) applies, at the option of the Federal agency, in situations where a statute authorizes the Federal action to be taken in incremental steps. Such circumstances existed in *North Slope Borough* v. *Andrus*, 642 F.2d 589 (D.C. Cir. 1980), involving development of oil and gas resources on the OCS and possible impacts to the bowhead whale. In view of this decision, these regulations provide that a Federal agency may proceed with incremental steps toward completion of the entire action if: (1) the biological opinion does not conclude that the incremental step would violate section 7(a)(2); (2) the Federal agency continues consultation with respect to the entire action and obtains biological opinions, as required, for each incremental step; (3) the Federal agency fulfills its continuing obligation to obtain sufficient data upon which to base the final biological opinion on the entire action; (4) the incremental step does not violate section 7(d) of the Act concerning irreversible or irretrievable commitment of resources; and (5) there is a reasonable likelihood that the entire action will not violate section 7(a)(2) of the Act.

In response to one comment, the Service acknowledges that the incremental step process can only be invoked at the option of the Federal agency, regardless of the Service's preference. If the Federal agency chooses not to use the incremental step process, the Service must render its biological opinion for the entire action.

Several commenters thought that this provision should be deleted. Some thought the subject should be handled through counterpart regulations or limited strictly to Outer Continental Shelf Lands Act cases. Another commenter stated that the incremental step approach is ill-advised because it is difficult to halt a project at its final stage after substantial resources have been invested. Finally, two commenters criticized the approach as a vehicle granting the Service veto power at any stage of the Federal action.

Paragraph (k) is retained in the final rule for several reasons. First, the Service adopts paragraph (k) because it provides a viable consultation approach sanctioned by the court in *North Slope Borough* v. *Andrus, supra*. The Service has clarified the final rule to show that it will not deprive a Federal agency of the opportunity to consult on incremental steps if requested. Second, the risk of section 7(a)(2) and 7(d) noncompliance should not be diminished because the incremental step approach is used. Monetary investments or other actions that do not foreclose the adoption of reasonable and prudent alternatives do not violate section 7(d). If a "jeopardy" opinion is issued at any step of the overall action, a prompt remedy can be sought through the exemption procedure. Third, consulting in incremental steps can be a valuable tool for developing information as an action progresses.

Oil and gas development on the OCS is a multistaged, long term action that provides a good example of the utility of an incremental step consultation. The Federal action occurs in discrete stages: the lease sale, exploration activities, and development/production activities. Any analysis of the impacts of development/production would be mere speculation without knowing what tracts will be leased and without the information on the extent of the petroleum reserves discovered during the exploration phase. As the scope and location of the ultimate action is further refined, the Federal agency will have the opportunity to conduct studies designed to determine the effects of that particular action in that particular area.

The Service is sympathetic to the commenter's concern that applicants might face an arduous series of consultations under paragraph (k), whereas a prompt consultation on the entire action would avoid a series of reviews by the Service. The Service reminds applicants that they may, in appropriate instances, avail themselves of the early consultation procedure to obtain a preapplication review of the remaining steps of the Federal action.

Under paragraph (k), biological opinions concluding "no jeopardy," or Service concurrence letters finding that a step "is not likely to adversely affect," must eventually cover each step of the incremental process. This does not mean that separate opinions must be issued for each step—several steps may be covered in one opinion (*e.g.*, OCS leasing and exploration activities)—but instead that each step must eventually satisfy section 7(a)(2) of the Act. A "jeopardy" opinion issued at any stage not only applies to that step but to the entire project as well. Once a "jeopardy" opinion is issued (unless the Federal agency adopts a reasonable and prudent alternative provided by the Service), paragraph (k) is inapplicable and the ordinary consultation process applies, allowing access to the exemption process. The commenter that contended that this approach is tantamount to a usurpation of Federal agency statutory authority ignores the fact that this process is at the option of the Federal agency and that the net effect of the Service's action is to cause the consultation to revert to a treatment of the action as a whole. The Federal agency may disagree with the Service's "jeopardy" finding, but it cannot continue to consult on an incremental basis on remaining steps in the action.

One commenter insisted that an action can be halted only if new information that was not previously known becomes available during a later stage of the incremental step consultation. However, the Service's responsibility to determine "jeopardy" or "no jeopardy" places no weight on when, where, or how data that is of compelling force in its analysis were developed. The Service cannot ignore data and permit a listed species to become jeopardized because someone "missed" a piece of information during an earlier step of the consultation. One of the criteria for reinitiation of formal consultation is whether new information reveals effects of the action that may affect a listed species or critical habitat in a manner or to an extent not previously considered. Therefore, incremental step consultations are not the only consultations subjected to this requirement.

Finally, one commenter objected to the requirement for obtaining sufficient data, noting an alleged absence of statutory authority. Again, paragraph (k) is not a creature of statute, but instead was developed so that consultations could be initiated and focused on a step-by-step review of segmented Federal actions—especially those where, in the absence of additional information, the final determination of "likely jeopardy" for the entire action would be highly speculative if consultation were not limited to the initial step or steps. The development of sufficient information is crucial to the ultimate success of the incremental step process, and, therefore, cannot be eliminated from the rule. The Federal agency must have sufficient information to show that its action is not likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat.

Section 402.14(l) covers the termination of formal consultation. Adopted from proposed §402.15(i)(2)–(4), paragraph (l) was retained in the section

on formal consultation because §402.14 is the primary mandatory procedure of Part 402.

The proposed rule provided that consultation terminated with the issuance of a "no jeopardy" opinion unless further discussion took place, and, if a "jeopardy" opinion was issued, consultation terminated with the Service's receipt of the Federal agency's decision on the action. This notice requirement was criticized by several commenters as unnecessary and as extending consultation beyond the legal timeframe. As discussed under the "Definitions" section above, further discussion has been deleted as a formal step in the consultation process. Further, to accommodate the concerns, consultation terminates with the issuance of the biological opinion, whether "jeopardy" or "no jeopardy." However, the Service believes that the Federal agency notice of final action with respect to "jeopardy" opinions represents a minimal burden and has retained it under §402.15—"Responsibilities of Federal agency following issuance of a biological opinion." The Service agrees that a copy of the NEPA record of decision would meet the notice provisions of §402.15(b); the Service disagrees that this approach causes problems with NEPA compliance.

Finally, one commenter suggested that written notice be required to terminate consultation if a Federal agency or applicant decides to cancel plans for the action that is the subject of the consultation. The Service agrees that a written notice of termination is preferred, and has adopted the commenter's suggestion in paragraph (l)(2).

Section 402.15 Responsibilities of Federal Agency Following Issuance of a Biological Opinion.

Following the receipt of the Service's biological opinion, the Federal agency will make its final decision on the action. Section 402.15 describes the steps that the Federal agency should take after consultation is concluded. Paragraphs (a) and (c) of this section are adopted substantially without change from proposed §402.17. Paragraph (b) is adopted from proposed §402.15(i)(3) (last sentence).

Several commenters asked that the Federal agency be required to provide a statement of its reasons if it has chosen to disregard the Service's biological opinion. The Service declines to implement this request, because it remains the responsibility of each Federal agency to insure that it is in compliance with section 7(a)(2) and that it has established an administrative record for a given activity which demonstrates such compliance.

Federal courts have accorded Service biological opinions great deference. It, therefore, is incumbent upon a Federal agency to articulate in its administrative record its reasons for disagreeing with the conclusions of a biological opinion. But this is a matter which is primarily controlled under the provisions and judicial interpretations of the Administrative Procedure Act, not these regulations. Thus, the requested modification would add nothing that is not already required as a matter of administrative law.

Paragraph (c) points out the availability of an exemption process if the Federal agency determines that its proposed action cannot comply with section 7(a)(2). Although not covered in §402.15, the applicant may also pursue an exemption if it receives a final denial of its application as a result of a "jeopardy" biological opinion. The Service disagrees with one commenter that the applicant may seek an exemption if the Federal agency issues the permit or license with conditions related to section 7 considerations. The Act requires a final agency denial, and the issuance of a "jeopardy" biological opinion on the action, as predicates for an applicant's entry into the exemption process. See sections 3(12) and 7(g)(1) of the Act.

Section 402.16 Reinitiation of Formal Consultation.

Reinitiation of formal consultation is required in certain instances as specified in §402.16. The reinitiation requirement applies only to actions that remain subject to some Federal involvement or control. In the case where a permit or license had been granted, reinitiation would not be appropriate unless the permitting or licensing agency retained jurisdiction over the matter under the terms of the permit or license or as otherwise authorized by law.

In response to one comment, the Service notes its lack of authority to require Federal agencies to reinitiate consultation if they choose not to do so. Nevertheless, the Service shall request reinitiation when it believes that any condition described in this section applies.

Pursuant to several public comments, several minor changes have been made to §402.16 (proposed §402.18). Proposed paragraph (a), dealing with nonconfirmation of preliminary biological opinions, was deleted since it is more properly covered in the discussion of early consultation. The standard for reinitiation on incidental take statements is clarified in new paragraph (a). Paragraph (c) is clarified to show that changes to the action that do not cause effects different from or additional to those considered in the biological opinion will not require reinitiation of formal consultation.

Summary

The Amendments made significant changes in the consultation requirements of section 7, and the Service believes that a consistent response by the Federal agencies to those Amendments, as implemented by this final rule, will facilitate successful compliance with section 7 of the Act. The Service believes that these regulations will serve as an effective tool for the early resolution of potential conflicts involving listed species.

The primary authors of this final rule are Michael Young and Nancy Sweeney, Department of the Interior; Patricia Carter, Patricia Montanio, and Michael Gosliner, Department of Commerce.

The Department of the Interior, as lead agency in the development of these regulations, has prepared an environmental assessment in conjunction with this rulemaking. On the basis of the environmental assessment, it has been determined that this is not a major Federal action significantly affecting the quality of the human environment within the meaning of section 102(2)(C) of the National Environmental Policy Act of 1969 (implemented at 40 CFR Parts 1500–1508). Therefore, an environmental impact statement need not be prepared. These procedural regulations simply provide a uniform approach for consultation required by section 7 of the Act. Compliance with the procedures in these regulations will not have any significant, direct, or indirect adverse environmental impact. It also has been determined that these regulations do not constitute major rules as defined in Executive Order 12291. The Department of the Interior has certified, under the terms of the Regulatory Flexibility Act (5 U.S.C. 601), that these regulations will not have a significant economic impact on a substantial number of small entities. The regulations are directed at Federal actions. The costs to small entities are those involved with timing and data gathering, if requested by the Federal agency. Even if the costs were passed on, the analysis under the Regulatory Flexibility Act has concluded that they are not substantial. The Department has determined that these rules do not contain "collection of information" or recordkeeping

requirements as defined by the Paperwork Reduction Act. The analyses under Executive Order 12291, the Regulatory Flexibility Act, and NEPA are available to the public at the Office of Endangered Species, U.S. Fish and Wildlife Service, at the address listed above.

List of Subjects in 50 CFR Part 402

Endangered and threatened wildlife, Fish, Intergovernmental relations, Plants (agriculture).

Regulation Promulgation

Accordingly, the Service revises 50 CFR Part 402 to read as follows:

PART 402—INTERAGENCY COOPERATION—ENDANGERED SPECIES ACT OF 1973, AS AMENDED

Subpart A—General

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Authority: 16 U.S.C. 1531 *et seq.*

Subpart A—General

§ 402.01 Scope.

(a) This Part interprets and implements sections 7(a)–(d) [16 U.S.C. 1536(a)–(d)] of the Endangered Species Act of 1973, as amended ("Act"). Section 7(a) grants authority to and imposes requirements upon Federal agencies regarding endangered or threatened species of fish, wildlife, or plants ("listed species") and habitat of such species that has been designated as critical ("critical habitat"). Section 7(a)(1) of the Act directs Federal agencies, in consultation with and with the assistance of the Secretary of the Interior or of Commerce, as appropriate, to utilize their authorities to further the purposes of the Act by carrying out conservation programs for listed species. Such affirmative conservation programs must comply with applicable permit requirements (50 CFR Parts 17, 220, 222, and 227) for listed species and should be coordinated with the appropriate Secretary. Section 7(a)(2) of the Act requires every Federal agency, in consultation with and with the assistance of the Secretary, to insure that any action it authorizes, funds, or carries out, in the United States or upon the high seas, is not likely to jeopardize the continued existence of any listed species or results in the destruction or adverse modification of critical habitat. Section 7(a)(3) of the Act authorizes a prospective permit or license applicant to request the issuing Federal agency to enter into early consultation with the Service on a proposed action to determine whether such action is likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat. Section 7(a)(4) of the Act requires Federal agencies to confer with the Secretary on any action that is likely to jeopardize the continued existence of proposed species or result in the destruction or adverse modification of proposed critical habitat. Section 7(b) of the Act requires the Secretary, after the conclusion of early or formal consultation, to issue a written statement setting forth the Secretary's opinion detailing how the agency action affects listed species or critical habitat Biological assessments are required under section 7(c) of the Act if listed species or critical habitat may be present in the area affected by any major construction activity as defined in §404.02. Section 7(d) of the Act prohibits Federal agencies and applicants from making any irreversible or irretrievable commitment of resources which has the effect of foreclosing the formulation or implementation of reasonable and prudent alternatives which would avoid jeopardizing the continued existence of listed species or resulting in the destruction or adverse modification of critical habitat. Section 7(e)–(o)(1) of the Act provide procedures for granting exemptions from the requirements of section 7(a)(2). Regulations governing the submission of exemption applications are found at 50 CFR Part 451, and regulations governing the exemption process are found at 50 CFR Parts 450, 452, and 453.

(b) The U.S. Fish and Wildlife Service (FWS) and the National Marine Fisheries Service (NMFS) share responsibilities for administering the Act. The Lists of Endangered and Threatened Wildlife and Plants are found in 50 CFR 17.11 and 17.12 and the designated critical habitats are found in 50 CFR 17.95 and 17.96 and 50 CFR Part 226. Endangered or threatened species under the jurisdiction of the NMFS are located in 50 CFR 222.23(a) and 227.4. If the subject species is cited in 50 CFR 222.23(a) or 227.4, the Federal agency shall contact the NMFS. For all other listed species the Federal Agency shall contact the FWS.

§ 402.02 Definitions.

"Act" means the Endangered Species Act of 1973, as amended, 16 U.S.C. 1531 *et seq.*

"Action" means all activities or programs of any kind authorized, funded, or carried out, in whole or in part, by Federal agencies in the United States or upon the high seas. Examples include, but are not limited to: (a) actions intended to conserve listed species or their habitat; (b) the promulgation of regulations; (c) the granting of licenses, contracts, leases, easements, rights-of-way, permits, or grants-in-aid; or (d) actions directly or indirectly causing modifications to the land, water, or air.

"Action area" means all areas to be affected directly or indirectly by the Federal action and not merely the immediate area involved in the action.

"Applicant" refers to any person, as defined in section 3(13) of the Act, who requires formal approval or authorization from a Federal agency as a prerequisite to conducting the action.

"Biological assessment" refers to the information prepared by or under the direction of the Federal agency concerning listed and proposed species and designated and proposed critical habitat that may be present in the action area and the evaluation potential effects of the action on such species and habitat.

"Biological opinion" is the document that states the opinion of the Service as to whether or not the Federal action is likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat.

"Conference" is a process which involves informal discussions between a Federal agency and the Service under section 7(a)(4) of the Act regarding the impact of an action on proposed species or proposed critical habitat and recommendations to minimize or avoid the adverse effects.

"Conservation recommendations" are suggestions of the Service regarding discretionary measures to minimize or avoid adverse effects of a proposed action on listed species or critical habitat or regarding the development of information.

"Critical habitat" refers to an area designated as critical habitat listed in 50 CFR Parts 17 or 226.

"Cumulative effects" are those effects of future State or private activities, not involving Federal activities, that are reasonably certain to occur within the action area of the Federal action subject to consultation.

"Designated non-Federal representative" refers to a person designated by the Federal agency as its representative to conduct informal consultation and/or to prepare any biological assessment.

"Destruction or adverse modification" means a direct or indirect alteration that appreciably diminishes the value of critical habitat for both the survival and recovery of a listed species. Such alterations include, but are not limited to, alterations adversely modifying any of those physical or biological features that were the basis for determining the habitat to be critical.

"Director" refers to the Assistant Administrator for Fisheries for the National Oceanic and Atmospheric Administration, or his authorized representative; or the Fish and Wildlife Service regional director, or his authorized representative, for the region where the action would be carried out.

"Early consultation" is a process requested by a Federal agency on behalf of a prospective applicant under section 7(a)(3) of the Act.

"Effects of the action" refers to the direct and indirect effects of an action on the species or critical habitat, together with the effects of other activities that are interrelated or interdependent with that action, that will be added to the environmental baseline. The environmental baseline includes the past and present impacts of all Federal, State, or private actions and other human activities in the action area, the anticipated impacts of all proposed Federal projects in the action area that have already undergone formal or early section 7 consultation, and the impact of State or private actions which are contemporaneous with the consultation in process. Indirect effects are those that are caused by the proposed action and are later in time, but still are reasonably certain to occur. Interrelated actions are those that are part of a larger action and depend on the larger action for their justification. Interdependent actions are those that have no independent utility apart from the action under consideration.

"Formal consultation" is a process between the Service and the Federal agency that commences with the Federal agency's written request for consultation under section 7(a)(2) of the Act and concludes with the Service's issuance of the biological opinion under section 7(b)(3) of the Act.

"Incidental take" refers to takings that result from, but are not the purpose of, carrying out an otherwise lawful activity conducted by the Federal agency or applicant.

"Informal consultation" is an optional process that includes all discussions, correspondence, etc., between the Service and the Federal agency or the designated non-Federal representative prior to formal consultation, if required.

"Jeopardize the continued existence of" means to engage in an action that reasonably would be expected, directly or indirectly, to reduce appreciably the likelihood of both the survival and recovery of a listed species in the wild by reducing the reproduction, numbers, or distribution of that species.

"Listed species" means any species of fish, wildlife, or plant which has been determined to be endangered or threatened under section 4 of the Act. Listed species are found in 50 CFR 17.11–17.12.

"Major construction activity" is a construction project (or other undertaking having similar physical impacts) which is a major Federal action significantly affecting the quality of the human environment as referred to in the National Environmental Policy Act [NEPA, 42 U.S.C. 4332(2)(C)].

"Preliminary biological opinion" refers to an opinion issued as a result of early consultation.

"Proposed critical habitat" means habitat proposed in the **Federal Register** to be designated or revised as critical habitat under section 4 of the Act for any listed or proposed species.

"Proposed species" means any species of fish, wildlife, or plant that is proposed in the **Federal Register** to be listed under section 4 of the Act.

"Reasonable and prudent alternatives" refer to alternative actions identified during formal consultation that can be implemented in a manner consistent with the intended purpose of the action, that can be implemented consistent with the scope of the Federal agency's legal authority and jurisdiction, that is economically and technologically feasible, and that the Director believes would avoid the likelihood of jeopardizing the continued existence of listed species or resulting in the destruction or adverse modification of critical habitat.

"Reasonable and prudent measures" refer to those actions the Director believes necessary or appropriate to minimize the impacts, *i.e.*, amount or extent, of incidental take.

"Recovery" means improvement in the status of listed species to the point at which listing is no longer appropriate under the criteria set out in section 4(a)(1) of the Act.

"Service" means the U.S. Fish and Wildlife Service or the National Marine Fisheries Service, as appropriate.

§402.03 Applicability.

Section 7 and the requirements of this Part apply to all actions in which there is discretionary Federal involvement or control.

§402.04 Counterpart regulations.

The consultation procedures set forth in this Part may be superseded for a particular Federal agency by joint counterpart regulations among that agency, the Fish and Wildlife Service, and the National Marine Fisheries Service. Such counterpart regulations shall be published in the **Federal Register** in proposed form and shall be subject to public comment for at least 60 days before final rules are published.

§402.05 Emergencies.

(a) Where emergency circumstances mandate the need to consult in an expedited manner, consultation may be conducted informally through alternative procedures that the Director determines to be consistent with the requirements of sections 7(a)–(d) of the Act. This provision applies to situations involving acts of God, disasters, casualties, national defense or security emergencies, etc.

(b) Formal consultation shall be initiated as soon as practicable after the emergency is under control. The Federal agency shall submit information on the nature of the emergency action(s), the justification for the expedited consultation, and the impacts to endangered or threatened species and their habitats. The Service will evaluate such information and issue a biological opinion including the information and recommendations given during the emergency consultation.

§402.06 Coordination with other environmental reviews.

(a) Consultation, conference, and biological assessment procedures under section 7 may be consolidated with interagency cooperation procedures required by other statutes, such as the National Environmental Policy Act (NEPA) (42 U.S.C. 4321 *et seq.*, implemented at 40 CFR Parts 1500–1508) or the Fish and Wildlife Coordination Act (FWCA) (16 U.S.C. 661 *et seq.*). Satisfying the requirements of these other statutes, however, does not in itself relieve a Federal agency of its

obligations to comply with the procedures set forth in this Part or the substantive requirements of section 7. The Service will attempt to provide a coordinated review and analysis of all environmental requirements.

(b) Where the consultation or conference has been consolidated with the interagency cooperation procedures required by other statutes such as NEPA or FWCA, the results should be included in the documents required by those statutes.

§ 402.07 Designation of lead agency.

When a particular action involves more than one Federal agency, the consultation and conference responsibilities may be fulfilled through a lead agency. Factors relevant in determining an appropriate lead agency include the time sequence in which the agencies would become involved, the magnitude of their respective involvement, and their relative expertise with respect to the environmental effects of the action. The Director shall be notified of the designation in writing by the lead agency.

§ 402.08 Designation of non-Federal representative.

A Federal agency may designate a non-Federal representative to conduct informal consultation or prepare a biological assessment by giving written notice to the Director of such designation. If a permit or license applicant is involved and is not the designated non-Federal representative, then the applicant and Federal agency must agree on the choice of the designated non-Federal representative. If a biological assessment is prepared by the designated non-Federal representative, the Federal agency shall furnish guidance and supervision and shall independently review and evaluate the scope and contents of the biological assessment. The ultimate responsibility for compliance with section 7 remains with the Federal agency.

§ 402.09 Irreversible or irretrievable commitment of resources.

After initiation or reinitiation of consultation required under section 7(a)(2) of the Act, the Federal agency and any applicant shall make no irreversible or irretrievable commitment of resources with respect to the agency action which has the effect of foreclosing the formulation or implementation of any reasonable and prudent alternatives which would avoid violating section 7(a)(2). This prohibition is in force during the consultation process and continues until the requirements of section 7(a)(2) are satisfied. This provision does not apply to the conference requirement for proposed species or proposed critical habitat under section 7(a)(4) of the Act.

Subpart B—Consultation Procedures

§ 402.10 Conference on proposed species or proposed critical habitat.

(a) Each Federal agency shall confer with the Service on any action which is likely to jeopardize the continued existence of any proposed species or result in the destruction or adverse modification of proposed critical habitat. The conference is designed to assist the Federal agency and any applicant in identifying and resolving potential conflicts at an early stage in the planning process.

(b) The Federal agency shall initiate the conference with the Director. The Service may request a conference if, after a review of available information, it determines that a conference is required for a particular action.

(c) A conference between a Federal agency and the Service shall consist of informal discussions concerning an action that is likely to jeopardize the continued existence of the proposed species or result in the destruction or adverse modification of the proposed critical habitat at issue. Applicants may be involved in these informal discussions to the greatest extent practicable. During the conference, the Service will make advisory recommendations, if any, on ways to minimize or avoid adverse effects. If the proposed species is subsequently listed or the proposed critical habitat is designated prior to completion of the action, the Federal agency must review the action to determine whether formal consultation is required.

(d) If requested by the Federal agency and deemed appropriate by the Service, the conference may be conducted in accordance with the procedures for formal consultation in § 402.14. An opinion issued at the conclusion of the conference may be adopted as the biological opinion when the species is listed or critical habitat is designated, but only if no significant new information is developed (including that developed during the rulemaking process on the proposed listing or critical habitat designation) and no significant changes to the Federal action are made that would alter the content of the opinion. An incidental take statement provided with a conference opinion does not become effective unless the Service adopts the opinion once the listing is final.

(e) The conclusions reached during a conference and any recommendations shall be documented by the Service and provided to the Federal agency and to any applicant. The style and magnitude of this document will vary with the complexity of the conference. If formal consultation also is required for a particular action, then the Service will provide the results of the conference with the biological opinion.

§ 402.11 Early consultation.

(a) *Purpose.* Early consultation is designed to reduce the likelihood of conflicts between listed species or critical habitat and proposed actions and occurs prior to the filing of an application for a Federal permit or license. Although early consultation is conducted between the Service and the Federal agency, the prospective applicant should be involved throughout the consultation process.

(b) *Request by prospective applicant.* If a prospective applicant has reason to believe that the prospective action may affect listed species or critical habitat, it may request the Federal agency to enter into early consultation with the Service. The prospective applicant must certify in writing to the Federal agency that (1) it has a definitive proposal outlining the action and its effects and (2) it intends to implement its proposal, if authorized.

(c) *Initiation of early consultation.* If the Federal agency receives the prospective applicant's certification in paragraph (b) of this section, then the Federal agency shall initiate early consultation with the Service. This request shall be in writing and contain the information outlined in § 402.14(c) and, if the action is a major construction activity, the biological assessment as outlined in § 402.12.

(d) *Procedures and responsibilities.* The procedures and responsibilities for early consultation are the same as outlined in § 402.14(c)–(j) for formal consultation, except that all references to the "applicant" shall be treated as the "prospective applicant" and all references to the "biological opinion" or the "opinion" shall be treated as the "preliminary biological opinion" for the purpose of this section.

(e) *Preliminary biological opinion.* The contents and conclusions of a preliminary biological opinion are the same as for a biological opinion issued after formal consultation except that the incidental take statement provided with a preliminary biological opinion does not constitute authority to take listed species.

(f) *Confirmation of preliminary biological opinion as final biological opinion.* A preliminary biological opinion may be confirmed as a

biological opinion issued after formal consultation if the Service reviews the proposed action and finds that there have been no significant changes in the action as planned or in the information used during the early consultation. A written request for confirmation of the preliminary biological opinion should be submitted after the prospective applicant applies to the Federal agency for a permit or license but prior to the issuance of such permit or license. Within 45 days of receipt of the Federal agency's request, the Service shall either: (1) confirm that the preliminary biological opinion stands as a final biological opinion; or (2) if the findings noted above cannot be made, request that the Federal agency initiate formal consultation.

§402.12 Biological assessments.

(a) *Purpose.* A biological assessment shall evaluate the potential effects of the action on listed and proposed species and designated and proposed critical habitat and determine whether any such species or habitat are likely to be adversely affected by the action and is used in determining whether formal consultation or a conference is necessary.

(b) *Preparation requirement.* (1) The procedures of this section are required for Federal actions that are "major construction activities"; provided that a contract for construction was not entered into or actual construction was not begun on or before November 10, 1978. Any person, including those who may wish to apply for an exemption from section 7(a)(2) of the Act, may prepare a biological assessment under the supervision of the Federal agency and in cooperation with the Service consistent with the procedures and requirements of this section. An exemption from the requirements of section 7(a)(2) is not permanent unless a biological assessment has been prepared.

(2) The biological assessment shall be completed before any contract for construction is entered into and before construction is begun.

(c) *Request for information.* The Federal agency or the designated non-Federal representative shall convey to the Director either (1) a written request for a list of any listed or proposed species or designated or proposed critical habitat that may be present in the action area; or (2) a written notification of the species and critical habitat that are being included in the biological assessment.

(d) *Director's response.* Within 30 days of receipt of the notification of, or the request for, a species list, the Director shall either concur with or revise the list or, in those cases where no list has been provided, advise the Federal agency or the designated non-Federal representative in writing whether, based on the best scientific and commercial data available, any listed or proposed species or designated or proposed critical habitat may be present in the action area. In addition to listed and proposed species, the Director will provide a list of candidate species that may be present in the action area. Candidate species refers to any species being considered by the Service for listing as endangered or threatened species but not yet the subject of a proposed rule. Although candidate species have no legal status and are accorded no protection under the Act, their inclusion will alert the Federal agency of potential proposals or listings.

(1) If the Director advises that no listed species or critical habitat may be present, the Federal agency need not prepare a biological assessment and further consultation is not required. If only proposed species or proposed critical habitat may be present in the action area, then the Federal agency must confer with the Service if required under §402.10, but preparation of a biological assessment is not required unless the proposed listing and/or designation becomes final.

(2) If a listed species or critical habitat may be present in the action area, the Director will provide a species list or concur with the species list provided. The Director also will provide available information (or references thereto) regarding these species and critical habitat, and may recommend discretionary studies or surveys that may provide a better information base for the preparation of an assessment. Any recommendation for studies or surveys is not to be construed as the Service's opinion that the Federal agency has failed to satisfy the information standard of section 7(a)(2) of the Act.

(e) *Verification of current accuracy of species list.* If the Federal agency or the designated non-Federal representative does not begin preparation of the biological assessment within 90 days of receipt of (or concurrence with) the species list, the Federal agency or the designated non-Federal representative must verify (formally or informally) with the Service the current accuracy of the species list at the time the preparation of the assessment is begun.

(f) *Contents.* The contents of a biological assessment are at the discretion of the Federal agency and will depend on the nature of the Federal action. The following may be considered for inclusion:

(1) The results of an on-site inspection of the area affected by the action to determine if listed or proposed species are present or occur seasonally.

(2) The views of recognized experts on the species at issue.

(3) A review of the literature and other information.

(4) An analysis of the effects of the action on the species and habitat, including consideration of cumulative effects, and the results of any related studies.

(5) An analysis of alternate actions considered by the Federal agency for the proposed action.

(g) *Incorporation by reference.* If a proposed action requiring the preparation of a biological assessment is identical, or very similar, to a previous action for which a biological assessment was prepared, the Federal agency may fulfill the biological assessment requirement for the proposed action by incorporating by reference the earlier biological assessment, plus any supporting data from other documents that are pertinent to the consultation, into a written certification that:

(1) The proposed action involves similar impacts to the same species in the same geographic area;

(2) No new species have been listed or proposed or no new critical habitat designated or proposed for the action area; and

(3) The biological assessment has been supplemented with any relevant changes in information.

(h) *Permit requirements.* If conducting a biological assessment will involve the taking of a listed species, a permit under section 10 of the Act (16 U.S.C. 1539) and Part 17 of this Title (with respect to species under the jurisdiction of the FWS) or Parts 220, 222, and 227 of this Title (with respect to species under the jurisdiction of the NMFS) is required.

(i) *Completion time.* The Federal agency or the designated non- Federal representative shall complete the biological assessment within 180 days after its initiation (receipt of or concurrence with the species list) unless a different period of time is agreed to by the Director and the Federal agency. If a permit or license applicant is involved, the 180-day period may not be extended unless the agency provides the applicant, before the close of the 180-day period, with a written statement setting forth the estimated length of the proposed extension and the reasons why such an extension is necessary.

(j) *Submission of biological assessment.* The Federal agency shall

submit the completed biological assessment to the Director for review. The Director will respond in writing within 30 days as to whether or not he concurs with the findings of the biological assessment. At the option of the Federal agency, formal consultation may be initiated under §402.14(c) concurrently with the submission of the assessment.

(k) *Use of the biological assessment.* (1) The Federal agency shall use the biological assessment in determining whether formal consultation or a conference is required under §402.14 or §402.10, respectively. If the biological assessment indicates that there are no listed species or critical habitat present that are likely to be adversely affected by the action and the Director concurs as specified in paragraph (j) of this section, then formal consultation is not required. If the biological assessment indicates that the action is not likely to jeopardize the continued existence of proposed species or result in the destruction or adverse modification of proposed critical habitat, and the Director concurs, then a conference is not required.

(2) The Director may use the results of the biological assessment in (i) determining whether to request the Federal agency to initiate formal consultation or a conference, (ii) formulating a biological opinion, or (iii) formulating a preliminary biological opinion.

§ 402.13 Informal consultation.

(a) Informal consultation is an optional process that includes all discussions, correspondence, etc., between the Service and the Federal agency or the designated non-Federal representative, designed to assist the Federal agency in determining whether formal consultation or a conference is required. If during informal consultation it is determined by the Federal agency, with the written concurrence of the Service, that the action is not likely to adversely affect listed species or critical habitat, the consultation process is terminated, and no further action is necessary.

(b) During informal consultation, the Service may suggest modifications to the action that the Federal agency and any applicant could implement to avoid the likelihood of adverse effects to listed species or critical habitat.

§ 402.14 Formal consultation.

(a) *Requirement for formal consultation.* Each Federal agency shall review its actions at the earliest possible time to determine whether any action may affect listed species or critical habitat. If such a determination is made, formal consultation is required, except as noted in paragraph (b) of this section. The Director may request a Federal agency to enter into consultation if he identifies any action of that agency that may affect listed species or critical habitat and for which there has been no consultation. When such a request is made, the Director shall forward to the Federal agency a written explanation of the basis for the request.

(b) *Exceptions.* (1) A Federal agency need not initiate formal consultation if, as a result of the preparation of a biological assessment under §402.12 or as a result of informal consultation with the Service under §402.13, the Federal agency determines, with the written concurrence of the Director, that the proposed action is not likely to adversely affect any listed species or critical habitat.

(2) A Federal agency need not initiate formal consultation if a preliminary biological opinion, issued after early consultation under §402.11, is confirmed as the final biological opinion.

(c) *Initiation of formal consultation.* A written request to initiate formal consultation shall be submitted to the Director and shall include:

(1) A description of the action to be considered;

(2) A description of the specific area that may be affected by the action;

(3) A description of any listed species or critical habitat that may be affected by the action;

(4) A description of the manner in which the action may affect any listed species or critical habitat and an analysis of any cumulative effects;

(5) Relevant reports, including any environmental impact statement, environmental assessment, or biological assessment prepared; and

(6) Any other relevant available information on the action, the affected listed species, or critical habitat.

Formal consultation shall not be initiated by the Federal agency until any required biological assessment has been completed and submitted to the Director in accordance with §402.12. Any request for formal consultation may encompass, subject to the approval of the Director, a number of similar individual actions within a given geographical area or a segment of a comprehensive plan. This does not relieve the Federal agency of the requirements for considering the effects of the action as a whole.

(d) *Responsibility to provide best scientific and commercial data available.* The Federal agency requesting formal consultation shall provide the Service with the best scientific and commercial data available or which can be obtained during the consultation for an adequate review of the effects that an action may have upon listed species or critical habitat. This information may include the results of studies or surveys conducted by the Federal agency or the designated non-Federal representative. The Federal agency shall provide any applicant with the opportunity to submit information for consideration during the consultation.

(e) *Duration and extension of formal consultation.* Formal consultation concludes within 90 days after its initiation unless extended as provided below. If an applicant is not involved, the Service and the Federal agency may mutually agree to extend the consultation for a specific time period. If an applicant is involved, the Service and the Federal agency may mutually agree to extend the consultation provided that the Service submits to the applicant, before the close of the 90 days, a written statement setting forth:

(1) The reasons why a longer period is required,

(2) The information that is required to complete the consultation, and

(3) The estimated date on which the consultation will be completed.

A consultation involving an applicant cannot be extended for more than 60 days without the consent of the applicant. Within 45 days after concluding formal consultation, the Service shall deliver a biological opinion to the Federal agency and any applicant.

(f) *Additional data.* When the Service determines that additional data would provide a better information base from which to formulate a biological opinion, the Director may request an extension of formal consultation and request that the Federal agency obtain additional data to determine how or to what extent the action may affect listed species or critical habitat. If formal consultation is extended by mutual agreement according to §402.14(e), the Federal agency shall obtain, to the extent practicable, that data which can be developed within the scope of the extension. The responsibility for conducting and funding any studies belongs to the Federal agency and the applicant, not the Service. The Service's request for additional data is not to be construed as the Service's opinion that the Federal agency has failed to satisfy the information standard of section 7(a)(2) of the Act. If no extension of formal consultation is agreed to, the Director will issue a biological opinion

using the best scientific and commercial data available.

(g) *Service responsibilities.* Service responsibilities during formal consultation are as follows:

(1) Review all relevant information provided by the Federal agency or otherwise available. Such review may include an on-site inspection of the action area with representatives of the Federal agency and the applicant.

(2) Evaluate the current status of the listed species or critical habitat.

(3) Evaluate the effects of the action and cumulative effects on the listed species or critical habitat.

(4) Formulate its biological opinion as to whether the action, taken together with cumulative effects, is likely to jeopardize the continued existence of listed species or result in the destruction or adverse modification of critical habitat.

(5) Discuss with the Federal agency and any applicant the Service's review and evaluation conducted under paragraphs (g)(1)–(3) of this section, the basis for any finding in the biological opinion, and the availability of reasonable and prudent alternatives (if a jeopardy opinion is to be issued) that the agency and the applicant can take to avoid violation of section 7(a)(2). The Service will utilize the expertise of the Federal agency and any applicant in identifying these alternatives. If requested, the Service shall make available to the Federal agency the draft biological opinion for the purpose of analyzing the reasonable and prudent alternatives. The 45-day period in which the biological opinion must be delivered will not be suspended unless the Federal agency secures the written consent of the applicant to an extension to a specific date. The applicant may request a copy of the draft opinion from the Federal agency. All comments on the draft biological opinion must be submitted to the Service through the Federal agency, although the applicant may send a copy of its comments directly to the Service. The Service will not issue its biological opinion prior to the 45-day or extended deadline while the draft is under review by the Federal agency. However, if the Federal agency submits comments to the Service regarding the draft biological opinion within 10 days of the deadline for issuing the opinion, the Service is entitled to an automatic 10-day extension on the deadline.

(6) Formulate discretionary conservation recommendations, if any, which will assist the Federal agency in reducing or eliminating the impacts that its proposed action may have on listed species or critical habitat.

(7) Formulate a statement concerning incidental take, if such take may occur.

(8) In formulating its biological opinion, any reasonable and prudent alternatives, and any reasonable and prudent measures, the Service will use the best scientific and commercial data available and will give appropriate consideration to any beneficial actions taken by the Federal agency or applicant, including any actions taken prior to the initiation of consultation.

(h) *Biological opinions.* The biological opinion shall include:

(1) A summary of the information on which the opinion is based;

(2) A detailed discussion of the effects of the action on listed species or critical habitat; and

(3) The Service's opinion on whether the action is likely to jeopardize the continued existence of a listed species or result in the destruction or adverse modification of critical habitat (a "jeopardy biological opinion"); or, the action is not likely to jeopardize the continued existence of a listed species or result in the destruction or adverse modification of critical habitat (a "no jeopardy" biological opinion). A "jeopardy" biological opinion shall include reasonable and prudent alternatives, if any. If the Service is unable to develop such alternatives, it will indicate that to the best of its knowledge there are no reasonable and prudent alternatives.

(i) *Incidental take.* (1) In those cases where the Service concludes that an action (or the implementation of any reasonable and prudent alternatives) and the resultant incidental take of listed species will not violate section 7(a)(2), the Service will provide with the biological opinion a statement concerning incidental take that:

(i) Specifies the impact, i.e., the amount or extent, of such incidental taking of the species;

(ii) Specifies those reasonable and prudent measures that the Director considers necessary or appropriate to minimize such impact;

(iii) Sets forth the terms and conditions (including, but not limited to, reporting requirements) that must be complied with by the Federal agency or any applicant to implement the measures specified under (ii) above; and

(iv) Specifies the procedures to be used to handle or dispose of any individuals of a species actually taken.

(2) Reasonable and prudent measures, along with the terms and conditions that implement them, cannot alter the basic design, location, scope, duration, or timing of the action and may involve only minor changes.

(3) In order to monitor the impacts of incidental take, the Federal agency or any applicant must report the progress of the action and its impact on the species to the Service as specified in the incidental take statement. The reporting requirements will be established in accordance with 50 CFR 13.45(FWS) and 222.23(d)(NMFS).

(4) If during the course of the action the amount or extent of incidental taking, as specified under paragraph (i)(1)(i) of this Section, is exceeded, the Federal agency must reinitiate consultation immediately.

(j) *Conservation recommendations.* The Service may provide with the biological opinion a statement containing discretionary conservation recommendations. Conservation recommendations are advisory and are not intended to carry any binding legal force.

(k) *Incremental steps.* When the action is authorized by a statute that allows the agency to take incremental steps toward the completion of the action, the Service shall, if requested by the Federal agency, issue a biological opinion on the incremental step being considered, including its views on the entire action. Upon the issuance of such a biological opinion, the Federal agency may proceed with or authorize the incremental steps of the action if:

(1) The biological opinion does not conclude that the incremental step would violate section 7(a)(2);

(2) The Federal agency continues consultation with respect to the entire action and obtains biological opinions, as required, for each incremental step;

(3) The Federal agency fulfills its continuing obligation to obtain sufficient data upon which to base the final biological opinion on the entire action;

(4) The incremental step does not violate section 7(d) of the Act concerning irreversible or irretrievable commitment of resources; and

(5) There is a reasonable likelihood that the entire action will not violate section 7(a)(2) of the Act.

(l) *Termination of consultation.* (1) Formal consultation is terminated with the issuance of the biological opinion.

(2) If during any stage of consultation a Federal agency determines that its proposed action is not likely to occur, the consultation may be terminated by written notice to the Service.

(3) If during any stage of consultation a Federal agency determines, with the concurrence of the Director, that its proposed action is not likely to adversely affect any listed species or critical habitat, the consultation is terminated.

§402.15 Responsibilities of Federal agency following issuance of a biological opinion.

(a) Following the issuance of a biological opinion, the Federal agency shall determine whether and in what manner to proceed with the action in light of its section 7 obligations and the Service's biological opinion.

(b) If a jeopardy biological opinion is issued, the Federal agency shall notify the Service of its final decision on the action.

(c) If the Federal agency determines that it cannot comply with the requirements of section 7(a)(2) after consultation with the Service, it may apply for an exemption. Procedures for exemption applications by Federal agencies and others are found in 50 CFR Part 451.

§402.16 Reinitiation of formal consultation.

Reinitiation of formal consultation is required and shall be requested by the Federal agency or by the Service, where discretionary Federal involvement or control over the action has been retained or is authorized by law and:

(a) If the amount or extent of taking specified in the incidental take statement is exceeded;

(b) If new information reveals effects of the action that may affect listed species or critical habitat in a manner or to an extent not previously considered;

(c) If the identified action is subsequently modified in a manner that causes an effect to the listed species or critical habitat that was not considered in the biological opinion; or

(d) If a new species is listed or critical habitat designated that may be affected by the identified action.

Dated: December 12, 1985.

William P. Horn,

Assistant Secretary for Fish and Wildlife and Parks.

Dated: January 30, 1986.

William G. Gordon,

Assistant Administrator for Fisheries, National Oceanic and Atmospheric Administration.

[FR Doc. 86-10566 Filed 6-86; 8:45 am]

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Federal Register

Tuesday
June 3, 1986

Part III

Department of the Interior

Minerals Management Service

Outer Continental Shelf Sulphur and Salt Leasing in the Gulf of Mexico; Notice

4310-MR

UNITED STATES
DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
Gulf of Mexico
Outer Continental Shelf (OCS) Sulphur and Salt Leasing
Request for Comments

Purpose of Notice

This Notice advises all interested parties of a possible sulphur and salt lease sale in the Gulf of Mexico and requests expressions of interest, information, and any general comments.

If it is decided to proceed with planning for a sale, the next step in the process is a Call for Information and Nominations which will be published in the Federal Register. Final delineation of the area for possible leasing would be made at a later date only after compliance with established departmental procedures, all requirements of the National Environmental Policy Act of 1969 (40 CFR 1501.7), and the Outer Continental Shelf Lands Act (OCSLA), as amended (43 U.S.C. 1331 et seq.).

Summary

The Secretary of the Interior is authorized under the OCSLA, as amended, to issue leases for oil, gas, sulphur, and other minerals on the OCS. The Department now seeks expressions of interest and information from industry, Federal Agencies, State and local governments, and other interested parties concerning a preliminary proposal to hold a sulphur offshore lease sale in the Gulf of Mexico. Comments are also requested on a preliminary proposal to lease salt to be used in the extraction of sulphur.

Sulphur leasing and mining are not new to the Gulf of Mexico Region. Sulphur was mined onshore from salt domes in the late 1800's, and the first underwater sulphur was mined from beneath Lake Peigneur, Louisiana, in 1932. The first Federal offshore sulphur leases were offered offshore Louisiana in 1954. A sulphur lease offering offshore Texas was held in 1965, and one other offering was conducted for offshore Louisiana in 1969. A total of 59 leases were awarded, only 4 of which are currently active. The first offshore sulphur mining operation began production in 1960 at Freeport Sulphur Company's Grand Isle Block 16 Mine in waters offshore Louisiana which are now under State jurisdiction. Freeport's second mine, the Caminada Mine, opened in 1968, but operations were suspended in 1969 because of decreased demand. This mine is located in Federal waters in Blocks 16, 17, 22, and 23, Grand Isle Area. Freeport Sulphur Company submitted a Unit Development Operations Coordination Document and Environmental Report in May 1985 for reactivation of the facility. The final Environmental Assessment (No. U-402) was completed in July 1985, and the plan was approved in August 1985. Work is currently underway to reactivate the Caminada Mine. Note that two salt leases, no longer active, were awarded in sales in 1960 and 1967.

The possibility of a Deep Stratigraphic Test Program is currently under consideration.

Description of Area

The general area covered by this Notice includes the central and western portions of the Gulf of Mexico between approximately 88° W. longitude on the east and approximately 97° W. longitude on the west and extends from the Federal-State boundary seaward to approximately 26° N. latitude. The entire area is offshore Texas, Louisiana, Mississippi, and Alabama and is divided into two general areas--the Central Gulf of Mexico and the Western Gulf of Mexico. However, only one sulphur and/or salt lease sale, which may involve parts of both areas, is being considered at this time.

The following list comprises the Leasing Maps and the OCS Official Protraction Diagrams used in identifying the two areas. (It is recognized that the areas appropriate for a sulphur lease sale will comprise a relatively small portion of the Central and Western Gulf.)

1. Central Gulf of Mexico

Leasing Maps

Outer Continental Shelf Leasing Maps - Louisiana Nos. 1 through 12. This set of 27 maps sells for $17.00.

Outer Continental Shelf Official Protraction Diagrams

These diagrams sell for $2.00 each.

NH 15-12	Ewing Bank	(approved December 2, 1976)
NH 16-4	Mobile	(approved April 19, 1983)
NH 16-7	Viosca Knoll	(approved December 2, 1976)
NH 16-10	Mississippi Canyon	(approved December 2, 1976)
NH 15-3	Green Canyon	(approved December 2, 1976)
NG 15-6	Walker Ridge	(approved December 2, 1976)
NG 16-1	Atwater Valley	(approved November 10, 1983)
NG 16-4	(No Name)	(approved December 2, 1976)

2. Western Gulf of Mexico

Leasing Maps

Outer Continental Shelf Leasing Maps - South Texas Nos. 1 through 4. This set of seven maps sells for $5.00.

Outer Continental Shelf Leasing Maps - East Texas Nos. 5 through 8. This set of nine maps sells for $7.00.

Outer Continental Shelf Official Protraction Diagrams

These diagrams sell for $2.00 each.

NG 14-3	Corpus Christi	(approved January 27, 1976)
NG 14-6	Port Isabel	(approved January 27, 1976)
NG 15-1	East Breaks	(approved January 27, 1976)
NG 15-2	Garden Banks	(approved December 2, 1976)
NG 15-4	Alaminos Canyon	(approved March 26, 1976)
NG 15-5	Keathley Canyon	(approved December 2, 1976)

Official Protraction Diagrams and Leasing Maps, referred to above, may be purchased from the Public Information Unit, Gulf of Mexico Region (telephone (504) 838-0519). Address: P.O. Box 7944, Metairie, Louisiana 70010

Instructions to Commenters

Information is requested on the following specific items in relation to sulphur and/or salt leasing. Respondents are advised that the names of commenters become a matter of public record as do comments offered in response to this Notice. It is suggested that responses to the first item below which are considered proprietary by the respondent be clearly identified so that they may be safeguarded accordingly.

Comments are requested on the following specific items:

1. Areas which might be included in a Call for Information and Nominations if it is deemed appropriate to proceed.
2. Technology proposed for exploration and production.
3. Technology proposed for transporting production to shore.
4. Suggested lease conditions.
5. Suggested size of lease.
6. Suggested lease terms.
7. The limits of water depth and mine depth beyond which the Frasch process is technologically infeasible. The extent to which these depth limits are a function of economics. Specify appropriate water depth and mine depth limits as well as limitations as to distance from shore for sulphur leases.
8. The need for a prelease Deep Stratigraphic Test Program and the preferred timing for it to be accomplished, e.g., prior to the identification of the Federal proposal or the Notice of Sale.
9. Conflicts anticipated in the event a tract is leased with sulphur/salt rights and oil and gas rights; i.e., can two lessees coexist on the same tract without operational conflicts?
10. Data and information available concerning the current and projected sulphur market and the importance of potential OCS sulphur resources.

Schedule for Responses

Expressions of interest and other information must be received within 45 days after the publication of this Notice. This information should be submitted to the Regional Supervisor, Leasing and Environment, Gulf of Mexico Region, P.O. Box 7944, Metairie, Louisiana 70010. Envelopes should be marked "Comments on Sulphur/Salt Leasing."

As stated earlier in this Notice, if it is decided to proceed with planning for a sale, the next step in the process is a Call for Information and Nominations which will be published in the Federal Register. Final delineation of the area for possible leasing would be made at a later date only after compliance with established departmental procedures, all requirements of the National Environmental Policy Act of 1969 (40 CFR 1501.7), and the OCSLA, as amended. Subject to a decision to proceed with a sulphur/salt lease sale, a final Notice of Sale will be published in the Federal Register detailing areas to be offered for competitive bidding, stating the terms and conditions for leasing and announcing the location, date, and time bids will be received and opened.

For further information, contact Harold Sieverding, Regional Supervisor, Leasing and Environment, at (504) 838-0755, or Chris Oynes, Chief, Offshore Leasing Management Division, at (202) 343-6906.

Because the adjacent States of Texas, Mississippi, and Louisiana have expressed an interest in leasing of sulphur in their submerged lands the Minerals Management Service has agreed to facilitate their initial information-gathering as to industry interest in such lands. Commenters who are interested in areas for sulphur and/or salt leasing or who wish to comment on the questions listed above for State lands offshore any of the above States are urged to reply directly to those States at the addresses shown below. Note that the protection for data considered proprietary may differ between the Federal Government and the States, and the Federal Government will not afford protection of information provided directly to any State.

Texas Addressee:
Dr. E. G. Wermund
Associate Director
Bureau of Economic Geology
P.O. Box X, University Station
Austin, Texas 78713

Mississippi Addressees:
(Send comments to both)
Dr. Richard L. Leard
Bureau of Marine Resources
P.O. Box 959
Long Beach, Mississippi 39560

Col. Charles Blalock
Executive Director
Department of Material Resources
O. Box 10385
ckson, Mississippi 39205

Louisiana Addressee: Dr. Charles G. Groat
Louisiana Geological Survey
P.O. Box G, University Station
Louisiana State University
Baton Rouge, Louisiana 70893

If commenters wish, a copy of information provided to the States may be sent to the Regional Supervisor at the address stated above.

Director, erals Management Service

Wm. D. Bettenberg

5/28/86
Date

[FR Doc. 86-12316 Filed 6-2-86; 8:45 am]
BILLING CODE 4310-MR-C

Federal Register

Tuesday
June 3, 1986

Part IV

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405 and 412

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1987 Rates; Proposed Rule

Medicare Program; Changes to the DRG Classification System; Final Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 412

[BERC-353-P]

Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1987 Rates

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to amend the Medicare regulations governing the inpatient hospital prospective payment system to implement necessary changes arising from legislation and our continuing experience with the system and also from certain recommendations of the Prospective Payment Assessment Commission. Included in these proposed changes is our plan for incorporating capital payments into the prospective payment rates.

In addition, we are proposing changes in the methods, amounts, and factors necessary to determine prospective payment rates for Medicare inpatient hospital services. These changes would be applicable to discharges occurring on or after October 1, 1986. We are also setting forth our proposal for determining the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

DATE: To be considered, comments must be mailed or delivered to the appropriate address, as provided below, and must be received by 5:00 p.m. on July 3, 1986.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services. Attention: BERC-353-P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC.;

or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to file code BERC-353-P. Comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT: Linda Magno, (301) 594-9343.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary of the Implementation of the Prospective Payment System

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98-21) on April 20, 1983, a prospective payment system for Medicare payment of inpatient hosptial services was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs).

We published an interim final rule in the **Federal Register** (48 FR 39752) on September 1, 1983 to implement the prospective payment system effective with hospital cost reporting periods beginning on or after October 1, 1983. Technical corrections for that rule were issued on October 19, 1983 (48 FR 48467).

In particular, we identified the prospective payment rates to be used for the first year of the transition period. We issued a final rule (49 FR 234) on January 3, 1984 to make changes resulting from our consideration of public comments that were received in response to the interim final rule. Technical corrections for that rule were issued on June 1, 1984 (49 FR 23010).

As a result of our first year of experience with the prospective payment system and to accommodate changes resulting from the enactment of the Deficit Reduction Act of 1984 (Pub. L. 98-369) on July 18, 1984, we published a final rule on August 31, 1984 (49 FR 34728) that further revised the prospective payment regulations. In addition, we made changes in the methods, amounts, and factors necessary to implement the second year of the transition period. Technical corrections on that final rule were issued on October 15, 1984 (49 FR 40167).

On March 29, 1985, we published a final rule (50 FR 12740) that redesignated the prospective payment regulations under a new 42 CFR Part 412. These regulations were previously located in 42 CFR 405.470 through 405.477.

Taking into consideration the recommendations made by the Prospective Payment Assessment Commission (ProPAC) under the authority of section 1886(d)(4)(D) of the Act, we published a final rule on September 3, 1985 (50 FR 35646) to implement the third year of the transition period. Technical corrections on that final rule were issued on October 28, 1985 (50 FR 43570). However, beginning on September 30, 1985, Congress enacted a series of statutory extensions of the hospital payment rates that were in effect on September 30, 1985. The effect was to delay implementation of the September 3, 1985 final rule with the result that the revised payment rates for hospitals covered by the prospective payment system, the rate-of-increase limits for hospitals excluded from that system, and the amendments to the limits on the count of interns and residents in § 412.118 (f)(2) and (f)(3), all of which were originally scheduled to be effective on October 1, 1985, were postponed through April 30, 1986. We notified the public about these extensions (50 FR 46651 and 49930, and 51 FR 4166) and, after the President signed the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272) into law on April 7, 1986, we issued an interim final rule with comment period on May 6, 1986 (51 FR 16772), to effectuate new Federal fiscal year (FY) 1986 hospital payment rates effective for discharges occurring on or after May 1, 1986 for prospective payment hospitals and for cost reporting periods beginning on or after October 1, 1985 for hospitals excluded from the prospective payment system.

To implement sections 9101 through 9105, and 9112 of Pub. L. 99-272, we announced the following in the May 6, 1986 interim final rule:

- A one-half of one percent increase in Federal and hospital-specific payment rates and the rate-of-increase limits for inpatient hospital services.
- A one-year extension of prospective payment system transition period except for hospitals located in the State of Oregon.
- Prospective application of the revised hospital wage index.
- Payments to hospitals for indirect costs of medical education.
- Payments for hospitals that serve a disproportionate share of low-income patients.
- Indirect teaching adjustment for certain clinics.

The comment period for the interim final rule ends on June 5, 1986. We plan to address timely comments on both the interim final rule and this proposed rule in the final rule that will follow this proposed rule.

B. Major Contents of This Proposed Rule

This proposed rule would be effective for the fourth year of operation of the prospective payment system. Following is a summary of the major changes that we are proposing to make to the system:

1. Incorporation of Capital Payments into the Prospective Payment System

Under section 1886(a)(4) of the Act, capital-related costs are excluded from the definition of "operating costs of inpatient hospital services" for cost reporting periods beginning before October 1, 1986. Because this requirement of the statute to distinguish between capital-related costs and other operating costs expires with cost reporting periods beginning on or after October 1, 1986 and in the absence of further legislation on this matter, we are proposing to incorporate capital-related costs into the prospective payment system effective with cost reporting periods beginning in FY 1987. Our proposed changes and the rationale for them are set forth in section II of this preamble.

2. Rebasing and Reweighting of the Hospital Market Basket

We are proposing to recompute the hospital market basket using data from a more recent base year (that is, "rebasing" the market basket). We are also proposing to recalculate the weights of each of the components of the hospital market basket (that is, "reweighting" the market basket cost categories) to reflect the—

- Inclusion of capital payments into the prospective payment system;
- Expansion in the number of market basket cost categories; and
- Revision of certain price proxies used to monitor the rate of inflation in the market basket.

The proposed changes are discussed in section III of this preamble. The market basket category weights would change not only because of the inclusion of capital but also due to rebasing, which reflects hospital changes in the purchase of goods and services used to furnish care.

3. Other Decisions and Regulations Changes

In section IV of this preamble, we discuss several decisions and current provisions of the regulations in 42 CFR Parts 405 and 412, not discussed elsewhere in this rule, as follows:

- Elimination of periodic interim payments;
- Establishment of a base period for hospitals newly subject to the rate-of-increase ceiling;
- Extension of the exclusion of alcohol/drug hospitals and units;
- Hospitals in redesignated rural counties which are surrounded on all sides by urban counties;
- Changes to referral center criteria;
- Retention of transfer policy; and
- Changes to the DRG classification system.

4. Determining Prospective Payment Rates and Rate-of-Increase Limits

In the addendum to this proposed rule, we set forth proposed changes to the methods, amounts, and factors for determining the FY 1987 prospective payment rates. We are also proposing new target rate percentages for determining the rate-of-increase limits for FY 1987 for hospitals excluded from the prospective payment system.

5. Market Basket Discussion

In Appendix A, we provide a technical discussion of the data sources used to estimate the market basket relative weights and the choice of price proxies.

6. Impact Analysis

In Appendix B, we set forth an analysis of the impact that the proposed changes described in this rule would have on affected entities.

7. Discussion of ProPAC Recommendations

ProPAC is directed by section 1886(d)(4)(D) of the Act to make recommendations to the Secretary with respect to adjustments to the DRG classification and weighting factors and to report to Congress with respect to its evaluation of any adjustments made by the Secretary.

ProPAC is also directed, by the provisions of section 1886(e)(2) and (e)(3) of the Act, to make recommendations to the Secretary on the appropriate percentage change factor to be used in updating the average standardized amounts beginning with Federal FY 1986 and thereafter. These recommendations are due to the Secretary no later than the first day of April before the beginning of each fiscal year. The statute requires that ProPAC, in making its recommendations, take into account changes in the hospital market basket, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

Under section 1886(e)(5) of the Act, we are required to publish the report of the ProPAC recommendations for FY 1987 as a part of this proposed rule. The report may be found in Appendix C of this proposed rule. The recommendations, and the actions we are proposing to take with regard to them (when an action is recommended), are discussed in detail in the appropriate sections of this preamble and in the addendum to this proposed rule. Those recommendations that are not specifically relevant to matters presented below are discussed in section V of this preamble. For the benefit of the reader and in order to provide some perspective on the overall nature of the ProPAC recommendations, we briefly summarize them here and indicate generally where they are discussed.

- *Update Factor:*

—Recommendation 1: Amount of the Update Factor.

For FY 1987 the standardized amounts should be updated by the projected increase in the hospital market basket; minus a combined policy target adjustment factor (referred to by ProPAC as a discretionary adjustment factor) for scientific and technological advancement, productivity, and site substitution; plus an allowance for the estimated increase in real case-mix complexity during FY 1986; and minus adjustments for the correction of market basket forecast errors in FY 1986 and the observed change in the case-mix index in FY 1986. (Addendum, section II.A.)

- *Policy Target Adjustment Factors:*

—Recommendation 2: Allowance for Scientific and Technological Advancement and Productivity Goals, and Site of Care Substitution.

For the FY 1987 prospective payment rates, the combined allowance in the policy target adjustment factor for scientific and technological advancement, productivity improvement, and substitution in the site of service from inpatient to out-of-hospital settings should be set at minus 1.4 percent. (Addendum, section II.A.)

—Recommendation 3: Allowance for Real Case-Mix Change.

Real changes in case mix associated with changes in the characteristics of patients, rather than better coding of medical records, should be reflected in the prospective payments. The adjustment for real case-mix change should reflect both shifts in patients among the DRG categories and changes in the mix of patients within DRG categories. For the FY 1987 prospective

payment rates, the adjustment for real case mix should be set at a plus 0.9 percent. (Addendum, section II.A.)

• *Excluded Hospitals:*

—*Recommendation 4: Update Factor for Excluded Hospitals.*

In addition to the projected increase in the market basket (corrected for forecast errors), hospitals and hospital distinct part units excluded from the prospective payment system should receive an adjustment of minus 0.8 percent for productivity, and scientific and technological advancement goals. (Addendum, section III.C.)

• *Capital Payments:*

—*Recommendation 5: Including Capital in the Prospective Payment System.*

Beginning in FY 1987, the Secretary should initiate a transition to all-inclusive prospective prices that combine operating and capital cost components in a single prospective payment per case for hospitals. (Preamble, section II.E.)

—*Recommendation 6: Capital Payment Method.*

ProPAC recommends that we should make an adjustment to the standardized amounts for capital payments consisting of a Federal portion and a hospital-specific portion. The Federal portion of capital payments should be included as a fixed percentage add-on to the standardized amounts beginning in FY 1987. The Secretary should revise the hospital market basket as soon as possible to include capital components, as appropriate data become available, but no later than FY 1988. (Preamble, section II.E.)

—*Recommendation 7: Level of Capital Payment.*

For FY 1987, the level of capital payments, to be added to the standardized amounts, should be calculated based on average actual construction costs for FY 1985 projected forward, and average actual equipment costs for FY 1983 projected forward using current capital rules for distinguishing fixed plant and fixtures from moveable equipment. (Preamble, section II.E.)

—*Recommendation 8: Capital Payment Transition.*

There should be no transition period for the capital-related costs of moveable equipment. For the capital-related costs of fixed plant and fixtures, the transition period should be seven to ten years. The hospital-specific portion of capital payments should be based on the hospital's actual capital cost during each year of the transition. Capital payments for return on equity should be included in the hospital-specific portion of capital payments during the transition period only. (Preamble, section II.E.)

• *Adjustments to the Payment Formula:*

—*Recommendation 9: Disproportionate Share Hospital Adjustment.*

An adjustment to the prospective payment rates for hospitals serving a disproportionate share of low-income patients should be implemented as soon as possible. The adjustment, which should be similar to the adjustments under congressional consideration, should not change the total aggregate dollar amount paid to all hospitals. (Preamble, section V)

—*Recommendation 10: Improving the Definition of Hospital Labor Market Areas.*

The Secretary should improve the definition of hospital labor-market areas for FY 1987, if possible, but no later than FY 1988. For urban areas, the improved definitions should account for a greater amount of the wage variation between inner-city and suburban hospitals. For rural areas, the improved definitions should account for a greater amount of the wage variation between different rural areas within each State and between States. The implementation of improved definitions should not result in any change in aggregate hospital payments. (Preamble, section V)

—*Recommendation 11: Rural Hospitals.*

The Secretary should complete and publish congressionally mandated studies as soon as possible to determine whether changes in payment policies affecting rural hospitals, or other prospective payment modifications, are necessary. (Preamble, section V)

• *Medicare Cost Data:*

—*Recommendation 12: Earlier Availability of Medicare Cost Data.*

The Secretary should continue making cost data available as soon as possible as part of an ongoing effort, and should consider alternative strategies for sampling hospital cost data. (Preamble, section V)

• *Recalculating the Standardized Amount:*

—*Recommendation 13: Recalculating the Standardized Amounts.*

The Secretary should recalculate the standardized amounts using cost data that reflect hospital behavior under the prospective payment system to determine the update factor or to rebase the standardized amounts. (Addendum, section II.A.)

• *Recalibrating the DRG Weights:*

—*Recommendation 14: Recalibrating the DRG Weights.*

The DRG weights should be recalibrated annually in order to reflect the use of new technologies and other practice pattern changes affecting the relative use of hospital resources among DRGs. (Addendum, section II.C.)

• *Beneficiary Concerns:*

—*Recommendation 15: Beneficiary and Provider Information.*

The Secretary should provide more and better written information about the prospective payment system to beneficiaries and providers of services. (Preamble, section V)

—*Recommendation 16: Notice to Beneficiaries of Rights.*

Beneficiaries should be made aware of the process of reconsideration and appeal of a hospital denial of further inpatient services. They should be informed not to accept any oral communication to the effect that they must leave the hospital because their "coverage" has "run out" or because there is a limit on the number of days "allowed" by Medicare for a DRG. (Preamble, section V)

—*Recommendation 17: PRO Episode of Care Review.*

The focus of Peer Review Organization (PRO) quality of care review should be, to the extent possible, on the entire episode of care. The PRO's review should include, in addition to the period of hospitalization, the quality of care (and outcome) related to the overall episode of illness, including, if appropriate, skilled nursing or home health care. (Preamble, section V)

—*Recommendation 18: PRO Review of Outpatient Surgery and Procedures.*

PROs should be required to monitor outpatient surgery and procedures that used to be performed on an inpatient basis, particularly those which have been denied payment on preadmission review. (Preamble, section V)

—*Recommendation 19: Recalculating the Inpatient Hospital Deductible.*

The Secretary should seek a legislative change to the formula for computing the inpatient hospital deductible so that the annual increase in the deductible is more consistent with the annual per-case increase in Medicare payments to hospitals. Because the proportion of costs of inpatient hospital care borne by Medicare beneficiaries has inappropriately increased as a result of significant declines in length of stay experienced since the beginning of the prospective payment system, this proportion should be lowered to its calendar year 1983 level. (Preamble, section V)

• *Patient Classification and Case Mix:*

—Recommendation 20: Improving the Measurement of Hospital Case Mix.

While ProPAC believes that the DRG system is currently the most appropriate of the available measures of hospital case mix and should be retained in principle, resource use varies considerably within some DRGs. Therefore, ProPAC intends to continue its analysis of individual DRGs and to undertake a systematic evaluation of the entire system. (Preamble, section V)

—Recommendation 21: Process for Maintaining and Updating ICD–9–CM Codes.

The Secretary should establish a mechanism for maintaining and updating the International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM) diagnosis and procedure codes in a timely and effective manner. This process should include adequate educational support for all users. (Preamble, section V)

—Recommendation 22: Modification of ICD–9–CM Codes for Payment Purposes.

The Secretary should ensure that modifications of the ICD–9–CM diagnosis and procedure codes for payment purposes strictly adhere to coding rules and guidelines. In order to maintain the integrity and uniformity of the coding system, while allowing flexibility for payment purposes, the process for interpretation and assignment of existing ICD–9–CM codes should be assigned to one authorized group. (Preamble, section V)

—Recommendation 23: Interim Solution for Coding Problems.

The Secretary should establish an interim mechanism to allow identification of cases and appropriate DRG assignment when ICD–9–CM codes cannot be updated in a timely manner. (Preamble, section V)

• *DRG Classifications and Weighting Factors*

—Recommendation 24: Adjustment of the Labor Portion of the Standardized Amounts for Some DRGs Involving Expensive Devices.

The labor-related and nonlabor-related portions of the standardized amounts should be adjusted for DRGs with a high percentage of cases involving expensive devices. The new portions should more closely reflect the labor-related and nonlabor-related shares of costs for cases in DRGs No. 39 (lens procedures with or without vitrectomy), 104 (cardiac valve procedure with pump and with cardiac catheterization), 105 (cardiac valve procedure with pump and without cardiac catheterization), 209 (major joint and limb reattachment procedures), 471 (bilateral or multiple major joint procedures of the lower extremity), and the newly defined DRGs (see recommendations 25 through 28) for pacemaker implantation and replacement, implantable defibrillators, and penile prostheses. These adjustments should be made so that total hospital payments remain unchanged. The current labor-related and nonlabor-related portions of the standardized amounts should be calculated from data derived from HCFA's study of the labor portion of costs by DRG. If those data are incomplete, the portions should be calculated from available data on the charges and costs of medical supplies. The Secretary should study the need for similar adjustments in all DRGs. (Preamble, section V)

—Recommendation 25: Reclassification of Pacemaker Cases Based on Type of Device.

The DRGs involving implantation of cardiac pacemakers (currently DRGs 115 through 118) should each be restructured into two DRGs, one for cases involving dual-chamber or functionally similar pacemakers, and one for cases involving other single-chamber pacemakers. New ICD–9–CM procedure codes should be created to distinguish between these types of cases. A mechanism should be established to evaluate the appropriateness of all implants involving dual-chamber or functionally similar pacemakers. (Preamble, section V)

—Recommendation 26: Reclassification of Pacemaker Replacement Cases.

The cases involving replacement of a permanent cardiac pacemaker, except those with myocardial infarction, congestive heart failure, or shock, should be reassigned to DRGs that include only pacemaker replacements. (Preamble, section V)

—Recommendation 27: Implantable Defibrillator.

Implantable defibrillator cases should be assigned to a unique DRG. The labor portion and nonlabor portion of the standardized amounts should be adjusted for this new DRG to reflect the labor-related and nonlabor-related shares of costs for these cases. (Preamble, section V)

—Recommendation 28: Penile Prostheses.

Prior to recalibration, cases involving the implantation of a penile prosthesis should be removed from DRG 341 and reassigned to a unique DRG. The labor portion and nonlabor portion of the standardized amounts should be adjusted for this new DRG to reflect the labor-related and nonlabor-related shares respectively of costs for these cases. (Preamble, section V)

—Recommendation 29: Additional Payment for Magnetic Resonance Imaging.

For a period of three years, Medicare should pay hospitals an additional amount for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a hospital under the prospective payment system. Under existing capital payment policy, the add-on for FY 1987 should be $124 for each scan performed in institutions in which Medicare pays for the capital costs of an MRI scanner and $282 for each scan performed in a hospital on a beneficiary who is a patient of another hospital. (The reason for the increased payment in this situation is that the hospital without an MRI scanner would receive a bill from the hospital that actually performs the scan. The charge would include both an operating component and a capital component.) In FY 1988 and FY 1989 the add-on amounts for all hospitals should be recalculated to reflect any change in the average cost of an efficiently produced scan. (Preamble, section V)

—Recommendation 30: Extracorporeal Shock Wave Lithotripsy.

Cases in which extracorporeal shock wave lithotripsy is the principal procedure should temporarily be removed from DRG 324 and reassigned to DRG 323. The payments and costs for all cases in this DRG should be monitored to determine the appropriateness of prospective payments for operating costs. A unique DRG should be identified for this procedure. (Preamble, section V)

—Recommendation 31: Lymphomas and Leukemias.

Cases currently assigned to DRGs involving lymphoma, leukemia, and other related diagnoses (DRGs 400 through 404) should be reclassified into one of five newly defined DRGs. The new DRGs should allow a unique DRG for acute leukemia cases not involving a major operative procedure, eliminate age as a criterion for DRG assignment, and modify present classification based on operative procedure, complications, and comorbidity. Other ways of further improving these DRGs should continue to be explored. (Preamble, section V)

—Recommendation 32: Upper Extremity Procedures.

Cases involving procedures of the upper extremity that are currently classified in DRGs 223, 224, 228, and 229 should be reassigned based on anatomical location and the presence of complications and/or comorbidities, or systemic collagen vascular disease or implantation of joint prostheses. Nonsurgical hip fracture cases currently being assigned to DRGs 223, 224, 228, and 229 should be reassigned to the appropriate medical DRG. (Preamble, section V)

- *Data Development and Research:*

—*Recommendation 33: Maintaining a Commitment to Data Development and Research on the Prospective Payment System.*

The Secretary should continue to devote substantial resources to data development and research for monitoring and improving the prospective payment system and understanding its effects on the health care system. Studies mandated by Congress should be completed and made public, and new studies that analyze more recent data should be designed and initiated as soon as possible. (Preamble, section V)

II. Basis of Payment for Capital Under the Prospective Payment System

A. Introduction

We are proposing to change the regulations that apply specifically to the way in which certain hospital inpatient pass-through costs, collectively designated as capital-related costs (excluding payments to proprietary hospitals to provide them with a reasonable rate of return on equity capital), will be treated for Medicare program payment purposes effective with hospital cost reporting periods beginning on or after October 1, 1986. Pursuant to section 9107 of Pub. L. 99–272, payment for the return on equity capital also will be modified. These changes will be addressed in a separate rule-making document.

Capital-related costs under Medicare principles include depreciation, interest, taxes, insurance and similar expenses (defined further in § 405.414) for plant, fixed and moveable equipment. Under current Medicare reimbursement rules, payment for capital-related costs is on a reasonable cost basis (§ 405.402), both for hospitals subject to and excluded from the prospective payment system.

For prospective payment system hospitals, capital-related costs are not included in the prospective payment amount per discharge established for inpatient hospital services. These costs are excluded or "passed-through" (§ 412.113). For hospitals not subject to the prospective payment system, capital-related costs are excluded from the Pub. L. 97–248 ceiling on the rate of hospital cost increases because these costs are also excluded from the definition of inpatient operating costs subject to the limitation. This rule would eliminate the previous distinction maintained between capital-related and operating costs only for Medicare inpatient hospital services provided by hospitals subject to the prospective payment system for cost reporting periods beginning on or after October 1, 1986. We refer the reader to the discussion in section II.C.8. of the preamble regarding our proposed treatment of capital-related costs for Medicare inpatient hospital services for hospitals and hospital units excluded from the prospective payment system.

B. Background

Section 1886(a)(4) of the Act, as amended by section 601(a)(2) of the Social Security Amendments of 1983 (Pub. L. 98–21) and section 9107 of Pub. L. 99–272, states:

> For purposes of this section, the term "operating costs of inpatient hospital services" includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services as such costs are determined on an average per admission or per discharge basis (as determined by the Secretary). Such term does not include costs of approved educational activities, costs of anesthesia services provided by a certified registered nurse anesthetist, a return of equity capital, or, *with respect to costs incurred in cost reporting periods beginning prior to October 1, 1986, other capital-related costs, as defined by the Secretary.* (Emphasis added.)

The first statutory distinction between capital-related costs and total Part A hospital inpatient operating costs was made with the enactment of Pub. L. 98–21. Prior to that time capital-related costs were identified and treated separately for Medicare payment purposes only by regulatory exclusion from the inpatient routine operating cost limits (that is, section 223 limits under Pub. L. 92–603, for cost reporting periods beginning on or after July 1, 1979) and the Pub. L. 97–248 inpatient total operating cost limits and rate-of-increase limits. Section 601(a)(2) of Pub. L. 98–21, however, amended subsection 1886(a)(4) of the Act, specifying that the term "operating costs of inpatient hospital services" did not include costs that are defined by the Secretary as capital-related costs, but this exclusion of capital-related costs applies only to cost reporting periods beginning prior to October 1, 1986. Capital-related costs were, therefore, excluded from costs that are incorporated into the prospective payment system, State hospital reimbursement control systems or the Pub. L. 97–248 limits under section 1886 of the Act; they are instead subject to cost reimbursement provisions under section 1861(v).

Section 1886(d)(1)(A) of the Act establishes the prospective payment system as the sole basis for paying for "operating costs of inpatient hospital services (as defined in subsection (a)(4))" for hospital subject to that system. Since the definition of operating costs includes capital-related costs for cost reporting periods beginning October 1, 1986, or later, the Department lacks authority to continue reimbursement for capital-related costs on a cost reimbursement basis after that date. Because the current prospective payment rates were not set at levels designed to cover capital-related costs as well as operating costs as previously defined, we are proposing in this rule to establish prospectively-determined capital-related payment rates.

There are three provisions related to capital-related costs contained in Pub. L. 98–21 in addition to the revised definition of operating costs. The first is subsection 601(a)(3), which expresses congressional intent to incorporate capital-related costs into the prospective payment system and suggests the possibility that costs for newly obligated capital expenditures might be treated differently from previously obligated capital costs. Next, section 601(e) added subsection 1886(g)(1) to the Act, which applies if Congress fails to enact legislation relating to capital-related costs prior to October 1, 1986, and which prohibits payment of capital-related costs for hospital inpatient services resulting from capital expenditures obligated after September 30, 1986 unless the State has an agreement with the Secretary under section 1122 of the Act, and the State recommends approval for the capital expenditure. Another provision, section 603(a)(1), required the Secretary to study, develop and report to the Congress on the methods and proposals for legislation by which capital-related costs could be included within the prospective payment system.

This interim decision by Congress to continue cost-based reimbursement of capital-related expenses was based on the recognition that further study was desirable before these costs could be incorporated into the prospective payment system. Thus, under the provisions contained in Pub. L. 98–21, Congress included the requirement that the Secretary study capital-related costs and report to Congress on options for

including capital into the prospective payment system. The study was to be comprehensive and explore all options "including broadening the DRG payment to include a capital component, establishment of limits modeled on section 223 of Pub. L. 92–603 applicable to capital costs only, and the setting of limits on a statewide basis." This legislative history reflects congressional intent that the Secretary's report include specific recommendations "on the method and proposals for legislation by which capital-related costs, such as return on net equity . . . can be included within the prospective payment amounts" (quotation from House Report No. 98–25, Part 1, March 4, 1983).

A comprehensive report ("Hospital Capital Expenses: A Medicare Payment Strategy for the Future") containing the analyses and recommendations for incorporating hospital inpatient capital-related costs along with all other operating costs into the prospective payment system was submitted to Congress on March 14, 1986. That report forms the basis for this revision to the previous regulations that governed the treatment of capital-related costs. In the interim, however, capital-related costs are being reimbursed in accordance with the Medicare principles of reasonable cost reimbursement. As we noted in the March 14th report, we believe that amounts for capital can be appropriately included in the DRG payments. We believe that such a change in Medicare policy for capital would be a major step toward a more rational, less interventionist role for governnment in its capacity as a major third party payor. A primary purpose would be to assure that Medicare payments for capital are distributed to hospitals on an equitable basis directly related to their care of Medicare patients, while simultaneously correcting for the major shortcomings of cost reimbursement.

C. Proposed Changes to Capital Payment

1. Hospitals Subject to the Prospective Payment System

Although the statute (section 1886(a)(4) of the Act) simply incorporates capital-related costs into the definition of operating costs, we are proposing to use our exceptions and adjustments authority under section 1886(d)(5)(C)(iii) of the Act to create transition provisions and other refinements that will improve the equity of the system. The objective of this proposal is to set a Federal per-case payment for capital-related costs, initially as a separate component of the standardized amounts which would, after completion of the transition, be incorporated into the prospective payment standardized amounts as an integral part of the nonlabor portion for urban and rural areas. We propose to accomplish this by providing a four-year transition period, effective with cost reporting periods beginning on or after October 1, 1986, leading to fully national capital payment rates. During each year of the phase-in period, payments to hospitals would be based on a combination of a Federal capital rate and a hospital-specific capital rate. The proposed schedule for the phase-in period to national capital payment rates is indicated for each component in the following table:

For cost reporting periods beginning in Federal fiscal year—	Hospital-specific rate (percent)	Federal portion (perecent)
1987	80	20
1988	60	40
1989	40	60
1990	20	80
1991 on	0	100

We are proposing to add new §§ 412.65 through 412.67 to describe the new payment policy.

A four-year phase-in to fully national rates should ease the transition from the virtually unlimited cost pass-through approach. We recognize that this new payment approach could require hospitals to rethink their investment strategies in light of market conditions. Indeed, the intent of incorporating capital into operating costs as a single payment amount is to eliminate the disparate incentives created by paying a fixed amount for noncapital operating costs and a variable, largely unlimited, amount for capital costs. We believe that four years is a reasonable time period for a transition to full national payment rates. The incentives to substitute capital-related items and services for other operating costs in the inpatient hospital setting must be neutralized at the earliest reasonable time. The phase-in period for capital-related costs follows the same pattern established for the prospective payment system transition, which we believe provides adequate time to adjust inpatient operations.

2. Determination of Federal Capital Payment Rates

We propose to compute the Federal capital-related rate using audited hospital inpatient capital-related cost data from Medicare cost reports for reporting periods beginning on or after October 1, 1982 and before October 1, 1983 (that is, Federal FY 1983). These are the latest audited cost reports available for this purpose. Capital-related costs are defined in accordance with § 405.414 and include depreciation, interest, taxes, insurance, and similar expenses for plant, fixed and moveable equipment. The FY 1983 base-year capital cost data used to develop the Federal capital-related rates include all allowable inpatient capital-related costs incurred in providing services to Medicare beneficiaries in prospective payment hospitals.

a. *Adjustment to Capital-Related Base-Year Cost Data.* Medicare reimbursement principles require that interest expense on indebtedness be reduced by interest income earned from any source, except for interest income earned on funded depreciation. However, we believe that it is appropriate to offset interest income earned on funded depreciation from the calculation of the average capital-related cost per discharge. Currently, the exclusion of the offset for interest income on funded depreciation encourages equity versus debt financing of capital investments. We believe that this incentive is no longer appropriate because the prospective payment system provides sufficient incentives to encourage prudent acquisition of capital assets without the need for additional equity. Therefore, the capital-related costs used to develop the Federal rates will be reduced by an estimated amount which reflects interest income earned on funded depreciation. Because the necessary data to compute the amount of this offset are not available from the FY 1983 Medicare cost reports used to calculate the Federal capital-related rates, we are proposing to use an estimate derived from a special data element collected and audited for a sample of FY 1984 cost reports for this purpose.

b. *Calculation of Standardized Federal Capital Related Amounts.* Section 1886(d)(2) of the Act specifies the manner in which the Secretary must determine the national and regional prospective payment rates for the operating costs of inpatient hospital services. Because section 1886(a)(4) of the Act will no longer provide sufficient authority to exclude capital-related costs from the definition of inpatient operating costs effective with cost reporting periods beginning on or after October 1, 1986, we would follow the same rules for deriving Federal Capital-related rates, essentially as prescribed in section 1886(d)(2) of the Act, for purposes of consistency and facilitating the eventual merger of all operating cost components into the Federal rates. This section requires that base-period cost

data be developed and modified in several ways (that is, inflated, standardized, grouped into payment cells, and averaged) to generate an average standardized amount per discharge for each payment area, that is, urban and rural, for each census division and the nation. In order to remain consistent with the prospective payment rules governing the transition from regional to national Federal rates, the Federal capital-related rate for discharges in Federal FY 1987 would be a blend of Federal regional (50 percent) and national (50 percent) rates. For discharges occurring in Federal FY 1988 and onward, the full national rate would be applicable. It should be noted, however, that we are not proposing special treatment for hospitals in Oregon with respect to the transition, as contained in section 9102(d)(4) of Pub. L. 99-272. Table 1 of section IV of the addendum contains the regional and national Federal capital-related standardized amounts.

Step 1—Average Capital-Related Cost Per Discharge. Audited Medicare inpatient capital-related costs for each of the approximately 4,000 hospitals for cost reporting periods beginning in Federal FY 1983 were obtained. The resulting Medicare cost was then converted to yield an average capital-related cost per discharge.

The average capital-related cost per discharge was then reduced by a factor of 10 percent, which represents the estimated amount of capital-related cost attributable to interest income earned on funded depreciation by prospective payment hospitals in Federal FY 1983. The percentage figure used was derived by dividing the Medicare share of interest income by the total Medicare capital-related cost for each of a selected sample of prospective payment hospitals for their FY 1984 cost report year. These hospital ratios were then averaged within each cell used to stratify the sample, and the resultant means were multiplied by the appropriate sample weights to obtain a nationally representative ratio for all prospective payment system hospitals. That figure, then, represents the average ratio of interest income off set to total capital-related costs for all prospective payment hospitals in the aggregate. There is no basis to expect that this ratio would vary substantially from year to year. As a result, the ratio based on FY 1984 cost report data represents the best information available to us to make this adjustment.

Step 2—Updating. The capital-related costs per discharge computed in step 1 were updated through FY 1986 to bring them to a common time period since the Federal standardized amounts would apply to discharges occurring during Federal FY 1987.

(a) The base-year capital-related cost per discharge was inflated through the end of Federal FY 1986 using the historical and projected calendar year annual rates of increase in the capital component of the hospital market basket in order to be consistent with the prospective payment methodology for all other operating costs. The rates of inflation used were as follows:

Calendar year	Inflation rate
1983	6.8
1984	6.7
1985	5.9
1986 (forecasted)	3.8

Step 3—Standardization. After the capital-related costs were inflated through September 30, 1986; they were further standardized to remove the effects of known sources of variation in hosptial costs that are subsequently recognized in the computation of each hospital's prospective payment rate. Because capital-related costs would be considered as other *nonlabor* standardized amounts, each hospital's capital-related costs would be standardized for the effects of case mix, indirect medial education costs, and the higher costs of treating a disproportionate share of low-income patients. The costs would not be standardized for an area wage adjustment because such an adjustment is necessary only for the labor portions of standardized amounts. In addition, because Alaska and Hawaii have a higher cost-of-living compared to other States, the capital-related costs for hospitals in these two States were also standardized by an appropriate cost-of-living factor. Each of these adjustments is discussed below.

(i) *Case Mix.* The standardization necessary to neutralize capital-related costs for the effects of hospital differences in case-mix was accomplished by dividing each hospital's inflated capital-related cost per discharge by that hospital's case-mix index. Tables 3a and 3b of section IV of the addendum contain the case-mix index values used for this purpose. The case-mix indexes were calculated using the DRG weighting factors contained in Table 5 of the September 3, 1985 final rule (50 FR 35722 through 35735). We computed each hospital's case-mix index by multiplying the weighting factor for each DRG by the number of its Medicare discharges classified in that DRG for Federal FY 1985, summing the products for each DRG and dividing that result by the hospital's total number of Medicare discharges for that period. (We note that FY 1985 case-mix indexes are based on the best data available for the most recent year in which billing information is reasonably complete.)

(ii) *Indirect Medical Education Costs.* After adjusting each hospital's capital-related cost per discharge for inflation and case-mix, we divided each hospital's cost by 1.0 plus the indirect medical education adjustment factor set forth in section 9104(a) of Pub. L. 99-272, and the percentage add-on for hospitals that serve a disproportionate share of low-income patients as described below. (For a detailed explanation of the basis for the revisions in the computation of the adjustment for indirect medical education costs, see the interim final rule of May 6, 1986 (51 FR 16775)). The formula for deriving the indirect medical education adjustment factor is as follows:

$$2 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1\right]$$

Example: Based on a hospital's prospective payment data for its cost reporting period in FY 1984, a hospital has an intern and resident-to-bed ratio of .2. Its adjustment factor equals:

$$2 \times [(1+.2)^{.405} - 1] = 2 \times (.07663) = .15327$$

This hospital's indirect medical education adjustment factor is .1533. Therefore, the factor used to standardize its capital-related costs for indirect medical education activities is 1+.1533 or 1.1533.

(iii) *Disproportionate Share.* After determining each hospital's capital-related cost per discharge for indirect medical education, we add to that figure an adjustment factor representing the percentage add-on for hospitals that serve a disproportionate share of low-income patients. In order to standardize each hospital's capital-related cost per discharge, we divide each cost by 1.0

plus the total of the indirect medical education and disproportionate share adjustment factors. This additive procedure would be used in order to be consistent with the way in which we calculate the payment amounts.

Section 9105 of Pub. L. 99–272 added a new section 1886(d)(5)(F) to the Act to require additional payments for these hospitals. Therefore, we believe it is essential to exclude from capital costs per discharge the higher payments that will be made to disproportionate share hospitals. Thus, we have adjusted the standardized capital-related rates in the same manner that the Federal rates for other operating costs are adjusted for disproportionate share payments (see section II.A. of the addendum). For an explanation of the criteria that a hospital must meet in order to qualify for an additional payment as a disproportionate share hospital and the amount of the disproportionate share add-on, see the May 6, 1986 interim final rule (51 FR 16776). In determining the disproportionate share adjustment factors for purposes of standardizing the capital-related costs, we used available data on the percentage of Medicaid days from Medicare cost reports with cost reporting periods beginning in Federal FY 1984 and the percentage of SSI/Medicare days for FY 1984 derived from matching FY 1984 SSI eligibility files to Medicare FY 1984 PATBILL records. These factors would be updated in the final rule using the percentages derived by matching FY 1985 SSI/Medicare days to FY 1985 Medicare PATBILL records.

(iv) *Cost-of-Living Factor for Alaska and Hawaii.* Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments as deemed necessary to take into account the unique circumstances of hospitals located in Alaska and Hawaii. Under the prospective payment system, hospitals in these two States are entitled to increased payments for the nonlabor component of the regional and national rates. Because we view capital-related costs as nonlabor expenses, we believe it is appropriate to standardize the capital-related cost per discharge for hospitals in Alaska and Hawaii by a factor that reflects the higher cost of living in these States. Accordingly, we divided the capital-related cost per discharge values for hospitals in Alaska and Hawaii by adjustment factors contained in the table below. These values are based on data obtained from the U.S. Office of Personnel Management.

Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Alaska—all areas	1.25
Hawaii:	
Oahu	1.225
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.15

Step 4—Computation of urban and rural averages. We computed separate averages of the capital-related standardized amounts from Step 3 for urban and rural hospitals (as defined in § 412.62(f)), nationally and for each census division. (We note that rural referral centers, as defined in § 412.96, would be paid the urban capital payment rate in the same manner as they are currently paid the urban Federal rate under the prospective payment system (§ 412.96 (d) and (e).) We believe that rural referral centers have capital expenditures similar to urban hospitals. Therefore, we are proposing to revise § 412.96 (d) and (e) to pay rural referral centers the urban capital payment rate.)

Step 5—Reduction for outliers. We reduced each of the average capital-related standardized amounts in Step 4 by the estimated proportion of total prospective payments that are for outlier cases.

Step 6—Indirect Medical Education Payment Equality Factor. We adjusted each of the average capital-related standardized amounts in Step 5 by the appropriate indirect medical education payment equality factor. This adjustment, which is required under section 9104(b) of P.L. 99–272, is further explained, and the factors stated, in section II.A.4.d of the Addendum.

Table I of Part IV of the addendum contains the rates thus determined. There may be changes in these rates to the extent additional cost report data are available at the time we prepare the final rule.

We are also considering an alternative method for developing the Federal capital-related payment amounts. Under this alternative, the updated capital-related cost per discharge, reduced for interest income on funded depreciation, would not be standardized for each hospital's indirect medical education adjustment factor, for disproportionate share payments, or possibly for case mix. We would, however, continue to apply the cost-of-living adjustment for hospitals located in Alaska and Hawaii. Thus, after the capital-related costs were updated and divided by the cost-of-living adjustment factors and possibly by the case-mix for each hospital, we would compute national and regional urban and rural average capital-related amounts. The effect of making payments under this alternative approach would be that the average Federal capital-related amount would, in essence, not be adjusted by a hospital's indirect medical education factor, its disproportionate share factor, or possibly the DRG weighting factor. Unlike the proposed method, which would provide increased capital payments for teaching hospitals and disproportionate share hospitals, this alternative would provide that all hospitals in a particular payment cell (urban or rural by region) would receive the same Federal capital payment per discharge, or, if the capital costs per case are standardized by each hospital's case-mix index, a payment that varied only with the DRG weighting factor for each discharge. We specifically invite comments on the appropriateness of using this alternative to construct the Federal national and regional capital-related payment amounts and of paying such amounts without adjusting them by the indirect medical education and disproportionate share adjustment factors of the DRG weighting factor.

3. Determination of Hospital Specific Capital-Related Payment Rates

The hospital-specific portion of the capital-related payment during the transition period would be made by comparing the amount of a hospital's capital-related costs in a base year (its hospital-specific capital-related rate), updated through each year of the transition with the total amount of its actual capital-related expenditures in each transition year. The lesser of the two amounts would determine the hospital-specific capital-related payment for inpatient services in each phase-in year. Computing the hospital-specific capital-related rate would be the first step in this process.

The hospital-specific capital-related rate would consist of the allowable capital-related cost per discharge during a base year, Federal FY 1986. Thus, the hospital-specific capital-related rate would be calculated on the basis of each hospital's audited inpatient capital-related costs from hospital cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986. These inpatient capital-related costs are defined in accordance with § 405.414, and exclude costs representing the allowable return on equity capital for prospective payment proprietary hospitals. Payment for the

return on equity capital will be treated as provided under section 9107 of Pub. L. 99–272. Section 9107 of Pub. L. 99–272 amended section 1886(g)(2) of the Act to provide for a three-year phase-out of the allowance for a return on equity capital for inpatient hospital services, effective with cost reporting periods beginning on or after October 1, 1986. This provision does not incorporate return on equity capital into inpatient operating costs. Therefore, we are not proposing to include a return on equity capital in the prospective payment system. The return on equity capital provisions in section 9107 of P.L. 99–272 will be addresed in another rulemaking document.

a. *Calculation of Capital-Related Hospital-Specific Rate.* The computation of the capital-related hospital-specific rate conforms to the calculation of the hospital-specific portion of the prospective payment rates for other inpatient operating costs first described in the interim final rule establishing the prospective payment system published on September 1, 1983 (see 48 FR 39773). A base-year cost per discharge is calculated and standardized to eliminate variation attributable to the hospital's Medicare case mix to derive the applicable amount per discharge to be used in computing the capital-related hospital-specific rate.

The base-year capital-related cost per discharge will be computed using fully audited capital cost data from the Medicare cost report for the 12-month (or 52–53 weeks) reporting periods beginning on or after October 1, 1985 and before October 1, 1986. The base-year capital costs include all allowable inpatient capital-related costs incurred in providing services to Medicare beneficiaries, as defined in accordance with § 405.414.

If a hospital has a base-year cost reporting period of other than 12 months, the capital-related cost from the latest and longest cost reporting period in the base period will be used to establish the necessary capital-related cost per case. The resulting cost per discharge would be adjusted by the applicable update factor to trend forward the cost per case to the same point as the other, standard 12-month base periods for further, appropriate updating (see step 4 below).

Step 1. For each hospital, determine the total audited Medicare inpatient capital-related costs for the base year pursuant to §§ 405.414 and 412.113(a), and divide the Medicare inpatient capital-related base-year costs by that hospital's number of reported Medicare discharges in that period to obtain an average capital-related cost per discharge.

Step 2. Divide the capital-related cost per discharge computed in step 1 by that hospital's case-mix index obtained from Table 3a or 3b of section IV of the addendum.

b. *Capital-Related Hospital Specific Payment Determination.* The capital-related hospital-specific payment amount would be computed from the following formula:

$$\text{Capital-Related Hospital-Specific Rate} \times \text{Prospective Payment Update Factor} \times \text{Transition \% for Capital Hospital-specific rate} \times \text{DRG Weight}$$

We are proposing that for each of the transition years, each hospital's total hospital-specific capital-related payments would be equal tothe lesser of—

- The sum of its capital-related hospital-specific amounts for the applicable cost reporting period, as determined by the above steps; or
- The total of its actual allowable Medicare inpatient capital-related costs for the applicable transition year times the applicable capital-related hospital-specific transition percentage.

Hospitals that increase their capital expenses per discharge during the transition would be paid their capital-related prospective payment. Those that decrease their capital expenses per discharge will be paid their actual costs.

4. New Hospitals

For purposes of incorporating capital payments into the prospective payment system, new hospitals would be paid on the basis of the full Federal capital-related rate (that is, there would be no capital-related phase-in period for these facilities). To qualify, a new hospital would have to meet one of the following requirements:

- The hospital—

—Is newly participating in the Medicare program (under present and previous ownership); and

—Does not have a complete 12-month cost reporting period ending on or before September 30, 1986; or

- The hospital meets the new ownership and bed occupancy requirements described in § 412.74(a)(2).

We are proposing to add a new § 412.66(g) to reflect this change.

5. Capital Expenditure Agreements

Section 1886(g)(1) of the Act provides that, if legislation concerning payment for capital-related costs for inpatient hospital services is not enacted before October 1, 1986, no payment may be made for capital-related costs of capital expenditures (as defined in section 1122(g) and except as provided in section 1122(j) of the Act) for inpatient hospital services in a State, if such expenditures are obligated after September 30, 1986, unless the State has an agreement with the Secretary under 1122(b) of the Act and under such agreement the State recommended approval of the capital expenditure. The conference report accompanying Pub. L. 98–21 (H.R. Rep. No. 98–47 at p. 189) expressing Congress's expectation with respect to this provision states, "However, if the Secretary has implemented a system of prospective payment for capital without legislative action and the mandatory section 1122 capital planning approval provision has gone into effect, the conferees intend that the Secretary will adjust the prospective payment for capital to reflect a disapproval project under section 1122."

We are opposed to the concept of imposing health planning requirements on the hospital industry such as those required under section 1122 of the Act since inclusion of capital payments into the prospective payment system will remove the incentive to substitute capital expenditures for operating components and provide a payment amount neutralized with respect to such incentives.

Because our capital payment proposal provides that the hospital-specific portion of the capital payment would be determined on a retrospective basis, we do not propose to adjust hospital-specific capital payments under this provision. However, capital-related costs for such disapproved expenditures would be considered nonallowable costs for Medicare cost reporting purposes.

In adjusting the Federal portion of the capital-related prospective payment amount, we are proposing that the adjustment be determined as a percentage of the total disapproved capital expenditures to total capital assets. For example, if a hospital has a disapproved capital expenditure of $1,000,000 and total capital assets of $10,000,000, the Federal portion of the capital-related prospective payments would be reduced by 10 percent. If the expenditure is demonstrated to be

completely unrelated to inpatient hospital services, no adjustment would be applied.

We are proposing to add a new § 412.65(b) to describe these requirements.

6. Sole Community Hospitals

Section 1886(d)(5)(C)(ii) of the Act requires the Secretary to take into account the special needs of sole community hospitals (SCHs) by using a special payment formula for hospitals so classified. In our effort to make capital-related payments consistent with the other provisions of the prospective payment system, we would apply the same prospective payment rate blends to SCHs provided in § 412.92(d) in making capital-related payments to SCHs for their cost reporting periods beginning on or after October 1, 1986. Thus, we would pay SCHs the capital-related payment rates for all discharges occurring in cost reporting periods beginning on or after October 1, 1986 at:

- 25 percent of the Federal capital-related standardized regional rate as determined in the foregoing discussion; plus
- 75 percent of its capital-related hospital-specific rate as determined in the above manner;
- Disregard the blending of Federal and hospital-specific capital-related rates applicable to all other hospitals; and
- Apply the additional payment provisions appropriate to SCHs under the prospective payment system pursuant to § 412.92(e) to include capital-related payment adjustments.

We are proposing to include this treatment of SCHs in a new § 412.67(h) and revise § 412.92 to reflect this change.

7. Hospitals and Units Not Subject to the Prospective Payment System

Under section 1886(b)(4)(A) of the Act, the Secretary may provide for exceptions to the method for determining the amount of payment to hospitals as he deems appropriate.

We believe that payments for capital-related costs of hospitals and units excluded from the prospective payment system should continue to be reimbursed on a reasonable cost basis. That is, for a limited time, we would not incorporate capital-related costs into the definition of "inpatient operating costs" for those facilities, using the Secretary's exception authority under section 1886(b)(4)(A) of the Act.

All other things being equal, we believe that capital costs ought to be included in the target rates of hospitals excluded from the prospective payment system. In fact, as discussed elsewhere in this document, section 1886(a)(4) of the Act requires that capital-related costs be included in the definition of inpatient operating costs for cost reporting periods beginning on or after October 1, 1986. However, the difference in reimbursement methods between the prospective payment system and excluded hospitals results in major differences in the way we believe hospitals will operate once capital is included in the definition of operating costs.

Prospective payment system hospitals are paid on the basis of a price per discharge. Under this system, we have no concern over how the hospital uses the payment it receives from the Medicare program (provided, of course, that the quality of care furnished to Medicare beneficiaries does not suffer). In fact, we encourage hospitals to be efficient by allowing them to keep the difference between their costs and the Medicare payment. Adding a capital component to the price per discharge provides each hospital a sum that represents payment for its capital expenditures. However, based on its needs, a hospital can use this payment in any way it chooses, consistent with the continuing provision of quality medical care.

Hospitals excluded from the prospective payment system, on the other hand, continue to be paid based on the actual reasonable costs they incur in furnishing services to Medicare beneficiaries subject to a rate of increase limitation. Adding a capital component to their target rates could produce conditions and incentives that are not in keeping with the Medicare program's emphasis on the efficient provision of quality care. For example, a hospital with a fully depreciated asset base in its base year would have little or nothing added to its target rate for capital costs. In the near future, when it must purchase new expensive assets to replace the fully depreciated assets, its target rate would most likely not be sufficient to account for the costs of the new assets. The hospital then would be faced with the necessity of reducing other expenditures in order to stay within its target rate (at the possible expense of a reduction in the quality of care), or it would be faced with seeking an exception, a time-consuming and administratively burdensome process.

On the other hand is the situation of a hospital that purchases major assets in its base year. The capital component of its target rate would be comparatively large. However, as the assets are depreciated year-by-year, its target rate would continue to be adjusted by an update factor, leading to an unnecessarily high target rate vis-a-vis the costs actually required to maintain an efficient facility. This situation could lead the hospital to engage in inefficient practices, since it would be reimbursed its actual costs up to its target rate. Or, the provider could qualify for an even larger incentive payment year-by-year, without making any increasing gains in efficiency.

Due to the above potential scenarios, we are proposing, for a limited time, to grant an exception to hospitals and units excluded from the prospective payment system. Their capital costs would continue to be paid on a reasonable cost basis. However, we note that it is our intention to establish an alternative to reasonable cost reimbursement for the capital-related costs of these excluded facilities.

D. Additional Provisions Under Consideration

Any prospective payment policy incorporating capital into the standardized amounts should, at the end of the transition, provide for a flow of total payments sufficient to cover current patient care operations of efficiently operated hospitals and to provide adequate funds to permit modernization, replacement, and expansion as needed to replenish the current stock of capital. Not every hospital needs to modernize or wholly replace itself every year, or even every five years. But the prospective payment system should be sufficient over the longer term (for example, 15–30 years) to permit necessary recapitalization in addition to the provision of current patient care services.

While the post-transition standardized prospective payment rates can be set to adequately compensate for the total capital and non-capital inpatient expenditures of efficiently operated facilities, the capital payment transition period will be a critical time for hospitals to adjust their operations and plans in preparation for a single comprehensive payment mechanism. As a result, even at the time of this publication, we are also considering several options to the preceding mechanisms for incorporating capital-related expenditures into the prospective payment system. The intent in considering these options is to ease the transition from cost-based reimbursement for all inpatient hospital capital-related expenditures and to assist any hospitals disadvantaged to a degree substantially in excess of the majority of hospitals during the phase-in period. The options under review fall into five main categories; however, two

or more combinations of alternatives may have to be considered or revised together since all of the options interact with each other. These alternatives, about which we are requesting comments regarding possible adoption in the final rule, are as follows:

- Transition rates that differentiate between plant and fixed equipment versus moveable equipment.
- Hospital-specific portion determined by using a rolling base year.
- Exception procedures for severely disadvantaged hospitals that would provide an adjustment to payments to certain hospitals which can document that their capital-related inpatient operating costs are in excess of their total capital-related payments to a degree that exceeds a prescribed threshold (for example, two times the capital-related Federal standardized rate).
- Lengthening the phase-in period.
- Variation in blending other than straight-line declining percentages.
- Occupancy rate adjustment to Medicare inpatient capital-related costs in the base year or years for purposes of determining capital payments.

Alternatives to Avoid Sudden and Severe Disruptions. We are seriously considering a capital proposal which would deal separately with long-term capital (plant and fixed equipment) and shorter term capital (moveable equipment), with a longer transition period to national rates for long-term capital and an immediate move to national rates for moveable equipment. This structure would be combined with a rolling base, possibly including taking into account low occupancy rates, for the hospital specific portion of long-term capital and an exceptions pool to provide relief to hospitals meeting specified exception criteria. Adoption of a proposal such as this would be designed to reduce the estimated savings of the basic proposal by about 25–30 percent. Additional funds for hospital capital may be needed in the short run to avoid sudden and severe disruption of hospital expectations.

1. Transition Rates Distinguishing Plant and Fixed Equipment From Moveable Equipment

Under this alternative, two categories of capital items would be treated differently in incorporating capital-related costs into the prospective payment system. Rather than bringing all capital item expenditures under the prospective payment system in the same fashion, the differences in cost, longevity and relative ease of substitution of items by services generally applicable to movable equipment from those factors for plant and fixed equipment would be addressed. Whereas plant and fixed items usually have much higher costs associated with them, require longer term commitments of money, and reduce hospital management flexibility to adjust or substitute for them, moveable equipment costs generally offer much shorter time-frames and lower cost factors which management can act on in a shorter period. As a result we are considering the possibility of including immediately all moveable equipment costs in the Federal prospective payment rates from the beginning of the transition period and providing a blend of Federal and hospital-specific amounts only for plant and fixed equipment during a lengthened transition. The amount included in the Federal rates would be based on the relative national percentage breakdown these two categories as estimated from cost reports and applied to all hospitals regardless of an individual hospital's actual ratio of plant and fixed equipment costs to their moveable equipment costs. Our objective in taking this approach would be to provide a transition period only for that portion of the costs for which hospitals require long time periods to adjust their operations and plans.

A variation on this approach would be to pay hospitals based on the costs reported in their 1986 cost reports for plant and fixed equipment related to debt service (principal and interest) and lease costs. Depreciation, as it is currently defined would not be paid on a hospital-specific basis. The actual allowable principal, interest and lease costs would have to be determined on a hospital by hospital basis, and payment could be continued either for the life of the asset or for a defined period of time. Thus, we would include all moveable equipment costs and the remainder of costs from fixed equipment and plant (after excluding the actual principal, interest and lease costs) in the standardized Federal rate. The basis for the hospital-specific payment would be limited to the hospital's actual debt service expenses for fixed equipment and plant. This approach would recognize the costs of debt and long term leases related to long-term obligations. However, funded depreciation as it is currently paid would not continue since it represents payment for replacement of plant and fixed equipment. This approach has the advantage that it provides for payment of existing hospital obligations related to plant and fixed equipment, allowing for a smoother transition to the per case payment system, and resolves a definitional issue of defining "old" capital. However, disadvantages include the need to significantly revise hospital cost reports, alter established accounting principles concerning depreciation, and perhaps adding administrative complexity to the existing system.

We have identified several problems that must be addressed before we could proceed with such approaches. Primarily, the data available from the Medicare cost reports are insufficient for purposes of making an exact distinction between plant and fixed equipment, and moveable equipment. The information in Medicare cost reports, for example, provides no identification of capital which is directly assigned to cost centers, whether interest is related to fixed or moveable equipment, and so forth. Those estimates that are available from other sources vary greatly, and generally use definitions of capital items that differ somewhat from Medicare.

A national proportion, of course, could be set based on adjusting cost report data for undesignated capital-related costs that are directly assigned. We might also give consideration to using American Hospital Association (AHA) data and AHA's classification of useful lives of assets, and data from other sources. Likewise, in order to pay a hospital-specific amount based on this distinction from current cost report data, the rules currently applied to define these two capital categories in program instructions (the Provider Reimbursement Manual, HCFA Pub. 15–1, sections 104.2 and 104.3 as distinct from sections 104.4 and 104.5) would have to be applied on a consistent basis from the hospital-specific base-year categories to all existing and new items and services during the transition period. This would be necessary to maintain the original proportions established to set the capital-related rate for plant and fixed equipment.

We believe that this phase-in approach could represent, administratively, a more complex system but would be beneficial in recognizing the difference between planning for and incurring the two types of capital expenditures and the different effects of the prospective payment system on hospital decisions regarding these cost components. Moveable equipment is purchased and turned over more frequently than plant or fixed equipment. Thus, hospitals which have invested highly in moveable equipment would not be as adversely affected by incorporating that component into the standardized capital-payment rates

immediately as they would be in the case of plant and fixed equipment. We believe that the majority of costs for moveable equipment acquired prior to implementation of the prospective payment system have been recovered already, reducing the need for a transition period for this component, as prospective payments would support future purchases. In fact, immediate inclusion of moveable item costs into the prospective payment system would provide funds for hospitals that have not been able to afford such purchases in the past.

While the two major components of capital items suggest a logical distinction be made in treatment for purposes of incorporating capital-related costs into the prospective payment system, the feasibility of doing so must be considered prominently in any decision on this option. On the other hand, hospital managers could simplify their budgeting process since they would know exactly how much payment would be received for moveable equipment and address more clearly the longer term planning and debt aspects of plant and fixed equipment. Similarly, we could address more readily concerns that may arise in a transition to fully standardized capital-related payments with a more homogeneous capital-related component limited to plant and fixed equipment. Unlike moveable equipment, for example, fixed equipment and plant costs continue for extended periods. Thus, hospitals would be more clearly in need of a longer transition period to enable them to meet the costs of such capital projects that they are currently engaged in or recently completed. Other remedies for hospitals significantly disadvantaged by phasing in a standardized rate for long-term capital items would be more readily targeted by other adjustments we could devise to assist them as well, such as an exceptions process. Comments on these interactive aspects of this proposal are specifically solicited.

2. Alternative Payment Bases—Rolling Base Year

Rather than paying the base year capital-related cost per discharge trended forward by inflation, the actual cost for each year could be used in making the hospital-specific portion of the blended amount in each transition year. The goal of this approach is to provide recognition for capital-related costs in the same manner as the hospital must do in meeting actual current expenses during the transition. Since hospitals may have made commitments for capital items and services in the immediate past which will bring added expenses during the transition, this approach would address the actual changes from year-to-year during the phase-in period.

We are concerned that use of a rolling base year, while addressing actual market place activity in a cost reimbursement mode, may have additional disadvantages. It may act as an incentive to hospitals to continue to substitute capital purchases for other operating cost components as appears to have been the case during the period while capital-related costs were a pass-through and paid under cost reimbursement principles. This would reduce incentives for hospitals to review and revise their past practices.

We would assume that hospital managers will not make extensive capital commitments when eventually faced with fully standardized payments if a rolling base-year calculation method were used. Also, the rolling base-year approach would better recognize the increased capital costs that a hospital may have committed itself to prior to implementation of the proposed changes on capital policy. Using a rolling base, however, continues to insulate providers, at least partially, from the risk inherent in assuming new financial obligations. During transition, a hospital continues to get a proportion of its costs, regardless of how prudent the acquisition is in light of changing Medicare program rules.

Of course, use of actual costs during transition would ease problems associated with long-term debt commitments that hospitals incur for capital-related items and services. This option would also be simpler to administer and ease the transition for more hospitals than it would disadvantage.

3. Transitional Exception Process for Hospitals Disadvantaged by Phasing Capital-Related Payments Into the Prospective Payment System

Under this option, we would consider a procedure to provide additional capital payments, or an increased level of payment, to hospitals that are financially disadvantaged by the change-over from cost reimbursement to average standardized payments for capital-related items and services. It has been suggested that within certain parameters such hospitals could be assisted from the pool of funds available for capital payments in order to meet their obligated capital-related expenditures when the capital-related payments fall substantially below the capital-related costs.

We believe that a reasonable approach to address this problem could be to provide an exception procedure for qualifying hospitals.

Under this approach an exception process would be established pursuant to the general authority granted to the Secretary under section 1886(d)(5)(C)(iii) of the Act to provide for exceptions and adjustments to prospective payment amounts as is deemed appropriate. The amounts to be paid under the capital payment exception process would be funded by a reserve of funds obtained by reducing the average standardized capital-related payment rates by a percentage sufficient to generate a pool equal to the amount estimated to be paid to hospitals meeting the exception criteria. This manner of assuring funds for eligible hospitals would be based on the comparable provisions in the law under section 1886(d)(2)(E) of the Act for similar payments made for routine operating cost outliers, and the general interest of the Congress and the Administration to maintain payment equity in new prospective payment system program initiatives. The amount of the reserve would be determined by an estimate of the expected amount of exceptions that would be granted based on the criteria for eligibility that is promulgated. We would anticipate a reduction of 5–10 percent in the capital-related standardized amounts for this process.

The criteria that we anticipate would be pertinent to easing a disadvantaged hospital's financial situation during the transition period would be specified within the following parameters:

(a) The first criterion that we would apply would be a test of the overall financial condition of the hospital. This would be done by setting a debt/equity ratio threshold that the hospital must meet before it could be eligible for any additional payment or rate adjustment. We believe that a ratio of current assets to current liabilities which exceeds 200 percent for the applicable hospital fiscal year would be an appropriate level for this threshold but we seek suggestions for a different level that can be strongly supported.

(b) Another criterion that a hospital would be required to meet in order to be eligible for an additional capital-related payment, or adjustment to its rates, would be a capital-related expense versus capital payment difference which exceeds a specified threshold. In a given transition year, based on its audited cost report, only those hospitals with inpatient per discharge capital-related costs in excess of 200 percent of the Medicare adjusted standardized capital payment for their payment area (region and urban and rural location) in that

fiscal year would be considered further. In determining the actual allowable capital-related expenses to be used in comparing the capital-related cost per discharge to the applicable capital payment rate, only costs associated with capital-related items and services that were obligated before a specified cut-off date, for example, before January 1, 1986, would be considered. We invite comments on the elements of this criterion that we have specified, that is the level (200 percent) of inpatient per discharge capital-related costs and the date (January 1, 1986) by which obligations must have been made.

(c) The final criterion we establish would be to consider the hospital's actual allowable total Medicare inpatient operating costs (including capital-related costs) for the applicable fiscal year, based on its audited cost report for that period, in comparison with its total payments under the prospective payment system provisions applicable to that period. We would condition approval of any additional payment or rate adjustment for capital-related items and services on whether the combined Medicare inpatient operating cost to payment ratio of each facility was negative before approving any adjustment for the capital-related component.

A hospital would have to meet all of the above criteria before an exception could be granted to its capital payments. Thus, for example, if the criteria suggested above were employed as stated, a hospital would have to have a ratio of current assets to liabilities of 200 percent or more, per discharge capital-related costs at least twice their capital-related standardized amount and total inpatient cost per discharge in excess of their total prospective and pass-through payment per discharge (capital and non-capital payments per case) in order to be considered for an adjustment under this option.

We believe that these criteria are essential as a minimum set of standards to measure the appropriateness of the need for a hospital which requests an exception to its capital-related transition payments and provide equitable treatment to all classes of hospitals regardless of location, size or other situational factors. The type of criteria selected should not undermine the overall program goals established for the prospective payment system with respect to inpatient operating costs subject to this program. Thus, these rules have been considered because they would not require reverting back to reasonable cost reimbursement rules and procedures, add significant reporting requirements, nor interfere with the intent to make Medicare inpatient payments neutral with respect to inherent incentives for management to substitute capital items and services for other operational approaches to providing service. We also believe it is extremely important to assure that hospitals that are benefiting from prospective payments for non-capital operating costs under the prospective payment system do not receive an additional advantage because only one component of the facility's inpatient operation far exceeds the average cost of other facilities in its payment areas.

We recognize that under this exception process and the criteria we would use, not all hospitals for which the standardized capital payment level is initially less than required to meet their total capital-related expense obligations will be assisted. In particular, there will be hospitals that will marginally miss meeting the criteria. However, without recourse to a methodology which, de facto, would return the program to a surrogate cost reimbursement basis, it would be administratively infeasible and excessively costly to address each hospital's situation uniquely in an incremental fashion. Such an approach clearly would subvert the expressly stated congressional intent in establishing the prospective payment system, that is, to move toward a fully prospective payment for inpatient hospital operating costs.

While we are aware that making provisions for such an adjustment for capital payments will reduce the average Federal payment rate that the majority of hospitals will be paid, we believe this method is reasonable and supportable within the context of the prospective payment system. We expect that reduction of the average capital payment rate would not exceed ten percent of the rates under this provision. The rate reduction would not affect the hospital-specific payment to each hospital and that component of the blend will be higher in the early years of the transition. Furthermore, at the time the exception process reduction ceases, the reserve would be returned to the pool of prospective payment system funds.

We believe that along with the broad authority of the Secretary to provide for such adjustments and exceptions, the pattern established by law in providing for special outlier payments for the non-capital operating costs associated with long-stay or high-cost cases (which called for a special mechanism so that some hospitals are not significantly disadvantaged by such cases) clearly applies to such a major additional component of operating costs as capital-related expenses represent. Thus, providing for an exception process and the pool of funds necessary to administer it appears to be the most equitable and reasonable approach to this problem.

In order to assure the actuarial soundness of the adjustments provided under this approach, we would limit the amount that could be paid to a hospital eligible for the exception. We anticipate that the additional payments or adjustments would be limited to a percentage of the excess of determined costs above the payment cut-off level, with an additional test to assure that the adjustment under this exception would not increase the total of Medicare inpatient hospital payments above total Medicare inpatient hospital costs in the pertinent cost reporting period.

4. Lengthening the Capital Payment Transition Period

Our proposal currently would result in a four-year declining straight-line blend for the hospital-specific portion and Federal rate components, although we are considering a longer phase-in period than the four years stated in our proposal which conforms with the prospective payment phase-in for other operating components of inpatient costs. Our objective is to assure that facilities have adequate time to adjust and plan for standardized capital payments that are fully integrated into total operating Federal-level rates of payment. While the non-capital operating expenses are being phased into the prospective payment system within four years, there are persuasive arguments supporting consideration for a longer transition for capital-related items and services. Those include the generally accepted fact that planning and commitments for capital-related expenditures are made well in advance of purchase or construction and represent a longer term and obligatory payout period. These factors limit the flexibility that organizations have to adjust to changes in revenues as quickly as can be expected in the case of most other operating cost components.

Nevertheless, such an approach could disadvantage many hospitals which have capital costs per case that would fall below the average standardized capital rates. In such cases, it is important to move ahead rapidly to replace their cost reimbursement payments, particularly where they need to begin replacement or expansion. A speedier transition, we believe, could

benefit many of those under-capitalized urban nonprofit and rural facilities. However, the apparent benefits must be weighed carefully in light of the inappropriate incentives of the current hospital-specific cost reimbursement policy which, as the basis of this entire program initiative, should be changed as quickly as possible. Of course, the anticipation of full incorporation of capital-related costs into the Federal standardized rates over a longer transition period should provide adequate incentive for hospitals to make adjustments to their planning and operations. Furthermore, we do not believe that any hospitals would be severely disadvantaged if this option is adopted.

This option appears to be less dependent on the remaining alternatives discussed here than those are on each other. Since lengthening the transition can be considered more directly related to the intractability of reducing or substituting other items and services for capital-related factors rather than the adequacy of the level of payment in this conversion process, it can be viewed as having less impact on the other options presented here.

5. Variations in Blending Federal and Hospital-Specific Rates During Transition

We are also reviewing the impact of using other than a straight-line declining blend for the hospital-specific rate in order to ease transition for hospitals whose capital-related expenses are substantially above the average due to recent construction, refinancing and other reasons. The objectives in this approach are to ease transition for such hospitals, recognizing the binding commitments made to their funds and recognize the distinction between other operating costs and the capital-related component.

Should a method of blending transition rates weighted toward increased hospital-specific portion percentages in the first years be warranted, we would increase the hospital-specific portion in the earlier years of transition so that those would roughly be double the respective later years of transition. Examples of this, varying according to length of transition period, are:

- 4-Year transition:

Year	Hospital-specific rate (percent)	Federal rate (percent)
1	90	10
2	70	30
3	50	50
4	30	70

- 7-Year transition:

Year	Hospital-specific rate (percent)	Federal rate (percent)
1	95	5
2	90	10
3	60	20
4	70	30
5	50	50
6	30	70
7	10	90

While we recognize that a blending weighted toward higher hospital-specific rates in the earlier years will help ameliorate the impact on hospitals with high capital-related costs per case and delay the advantage to a nearly equal proportion of hospitals below the average, we are most concerned that the former group will not have as much incentive to act quickly to adjust their capital-related component. This applies equally to the preceding option and, in concert, both may tend to delay appropriate action on the part of some facilities.

Further, if this option is selected, it may reduce or eliminate the need for other options (rolling base year, exception process) to be selected. We believe that use of several or all of the options presented here could be detrimental to the program's intent, that is, to increase hospital efficiency through more appropriate payment incentives and to establish a single payment per case as rapidly as is supportable.

6. Adjustment to Hospital-Specific Rates for Low Occupancy

The present proposal does not address situations in which some hospitals with low occupancy would be paid for their capital-related costs on the same basis as all other hospitals. Since some hospitals fall far below the average national levels for patient days per bed available and one of the major objectives of the prospective payment system is to provide incentives to reduce unused hospital beds available in this country, we believe this factor could be dealt with in developing the hospital-specific rate for such facilities. Whereas the Federal rates will provide incentives for overbedded hospitals to reduce unused resources, the hospital-specific portion of the capital payment blend during transition does not necessarily reinforce this incentive. This could be particularly onerous if the transition period were to be extended and a rolling base year used in computing the hospital-specific capital payment amount. As a result, we believe that a hospital-specific calculation based on a rolling base year could be changed to provide an adjustment when the occupancy rates are significantly below the national average. If, for example, the Secretary established the appropriate threshold at a total occupancy rate of 60 percent, when a hospital meets or falls below that threshold, the computation of the hospital-specific rate for that period would be modified as follows:

In determining the Medicare portion of the hospital's inpatient capital-related cost per diem in the cost report for the applicable period, we would inflate the number of total inpatient days in the cost reporting year by the percentage difference between the hospital's actual occupancy rate in that period and the 60 percent threshold to arrive at the cost per diem to be used in deriving its total inpatient capital-related cost for the period. Since that amount is used to establish the facility's total Medicare capital-related cost per case, an appropriate and proportional reduction in its rate per case would result in making the hospital capital payment for any such period. Thus, for example, a hospital with a 40 percent occupancy rate in a transition year would have its total inpatient days increased as though the hospital was operating at a 60% occupancy level, thereby reducing its cost per diem in the same proportion.

We believe this is a reasonable approach to build in an incentive for hospitals to reduce excess capacity. It is comparable to that which would exist on the Federal rate side of the capital payment rate and is necessary to such a balanced approach to immediately address this problem on a national level. We are, of course, particularly interested in the public's and industry's views on this method of dealing with this issue. Comments on this option should also focus on the appropriate threshold occupancy rate, which could be significantly different from the 60 percent level used in the example above.

E. ProPAC Recommendations on Capital Payment

The inclusion of capital into the prospective payment system represents one of the most significant changes to the system to date. The considerations regarded by ProPAC as most important in this process are that the capital payment system should—

—Provide for neutrality between capital and other operating expenditures;

—Reflect capital intensity variations across the DRGs and

—Contribute to controlling aggregate expenditures and the level of capital growth.

ProPAC devoted considerable attention to this area and made four specific recommendations.

1. Including Capital in the Prospective Payment System (Recommendation 5)

Beginning in FY 1987, the Secretary should initiate a transition to all-inclusive prospective prices that combine operating and capital-related cost components in a single prospective payment per case for hospitals.

ProPAC contends that retrospective cost-based reimbursement for capital-related costs lacks incentives for hospitals to minimize overall investment costs. Instead, it promotes insensitivity to interest rates and alternative financing methods. In addition, some hospitals may have invested in capital to produce services that exceed the demands of the inpatient hospital services market.

The combination of the Medicare prospective payment system and the capital pass-through has introduced additional distorted incentives to substitute capital for labor or other operating costs. As a result, a hospital that substitutes capital-related costs for operating costs (and assumes the risk of additional capital acquisition) receives more in total Medicare payments (that is, hospitals receive fixed DRG payments plus increased cost reimbursement for capital-related expenditures) than a hospital that does not substitute capital-related costs for operating costs due to the fact that the former is paid on a total allowable cost basis, while the latter is a standardized (that is, limited) amount of payment in all cases.

ProPAC strongly believes that the capital payment policy adopted should provide neutrality in capital-related cost and operating cost trade-offs. The payment method should not favor either capital-related or operating costs. Instead, it should encourage hospital managers to choose the optimal combination of those cost components. An all-inclusive payment rate would allow individual providers the flexibility to make what they consider to be the most cost-effective decisions based on the unique characteristics of their institutions.

We agree with the ProPAC views set forth describing the—

- Problems associated with paying for capital-related costs under cost-based reimbursement;
- Benefits of incorporating capital-related costs into an all-inclusive prospective payment rate; and
- Necessity of making this change at the earliest feasible time.

We also agree with the ProPAC observation that use and payment for capital-related cost items and services in inpatient and outpatient settings could overlap, and thereby result in unintended hospital practices and payment strategies. However, we believe that the ProPAC recommendations would not alleviate these concerns in a manner that is measurably more effective than the proposals we are presenting in this document for incorporating capital-related costs into the prospective payment system.

2. Capital Payment Method (Recommendation 6)

ProPAC recommends that the Federal portion of capital payments should be calculated as a fixed percentage add-on to the standardized amounts beginning in FY 1987 and that the Secretary should immediately develop capital components to be added to the hospital market basket. When appropriate data become available, the components of prospective payments should be recalculated to reflect the addition of capital costs. The results of this recomputation should be implemented as soon as possible, but no later than FY 1988.

Rather than using a percent add-on, we are proposing to use a fixed amount add-on to the prospective payment standardized rate for capital-related services. We would use this method since we have actual capital-related expenses from audited cost reports for the applicable base year. Furthermore, this approach conforms to the method used to develop the Federal rates for other operating costs when we implemented the prospective payment system. It should also be noted, that based on ProPAC's recommendations for setting the level of capital-related payments, separate trending and index factors also would be required. Differing factors for plant and fixed equipment, and movable equipment would be necessary because proxies for those items from manufacturing to interest rates would vary. Thus, we do not believe that full integration of the payment components could be accomplished during the phase-in period under any mechanism which deals with the components of capital-related items and services independently and involves a transition period to merge capital-related costs with all other operating costs. Only after the transition period would all operating cost components be merged into one, indistinguishable payment rate.

3. Level of Capital Payment (Recommendation 7)

ProPAC recommends that capital payment should be added to the Federal portion of the prospective payment rates for hospital accounting years beginning in FY 1987 in the following steps:

- For building and fixed equipment, average actual Medicare capital-related costs per discharge for FY 1985, projected forward to FY 1987 by an index of construction capital costs.
- For movable equipment, average actual Medicare capital costs per discharge for hospital cost reporting year FY 1983, projected forward to FY 1987 by an index of equipment capital costs.
- The proportion attributed to moveable equipment should be the lesser of the FY 1983 proportion or 40 percent.

ProPAC's basis for a capital-related payment mechanism distinguishes between plant and fixed equipment and moveable equipment. We believe ProPAC's approach represents a reasonable position, one which we have explored as well based on suggestions from the hospital industry and others during the past three years. However, we have not incorporated this approach in our proposal but will continue to consider it as a possible option pending further review of the data available, the potential complexity of this approach, and the comments received on this option before we make a final decision.

A national proportion could be set based on consideration of American Hospital Association (AHA).

ProPAC estimates that its proposal for the level of capital payment combined with the transition period will result in savings of approximately $8 billion over current pass-through payments during the next five years. For a more detailed discussion of the cost savings and impact of our proposed changes for capital payment, we refer the reader to the Regulatory Impact Analysis in Appendix B of this document.

4. Capital Payment Transition (Recommendation No. 8)

ProPAC recommends that the transition to Federal capital payments under the prospective payment system should begin in FY 1987 in accordance with the following provisions:

- There should be no transition for moveable equipment. All payments for moveable equipment should be included as a fixed percentage add-on to the Federal standardized amounts beginning in FY 1987.

• Payment for plant and fixed equipment should be phased in as a fixed percentage add-on to the Federal standardized amounts over a seven- to ten-year period on a straight line basis.

• For plant and fixed equipment, the hospital-specific capital payment portions should be based on the actual costs incurred during each year of the transition.

• During the transition, the Federal portion for plant and fixed equipment should be updated each year by an index of construction costs.

• The addition of capital to the Federal standardized amounts should reflect base-year treatment of return on equity and interest offsets. Return on equity payments should be added to the hospital-specific portion of operating costs. Once the transition to fully national rates for operating payments ends, there should be no hospital-specific payment for return on equity.

As noted in the explanation and discussion to the preceding recommendation, this approach is being assessed further by us in our consideration of alternative methods for incorporating capital-related costs into the prospective payment system.

ProPAC recommends that the addition of capital to the Federal standardized amounts should reflect base-year treatment of return on equity and interest offsets. Section 9107 of Pub. L. 99–272 precludes addressing return on equity payments as part of the capital-related payment being incorporated into the prospective payment system. As we indicated earlier, the changes to return on equity capital provision in section 9107 will be addressed in another rulemaking document.

III. Proposed Rebasing and Reweighting of the Hospital Market Basket

A. Background

For cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital "market basket") in establishing the limits on hospitals' routine operating costs (44 FR 31802). The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. Traditionally, we have used the market basket to adjust hospitals' cost limits by an amount that reflects the average increase in the prices of the goods and services used to furnish routine care. This approach linked the increase in the cost limits to the efficient utilization of resources.

With the inception of the prospective payment system on October 1, 1983, we have continued to use the market basket to update each hospital's 1981 inpatient operating cost per discharge used in establishing the FY 1984 standardized payment amounts. In addition, the projected change in the market basket is one of the integral components of the update factor by which the FY 1984 prospective payment rates were updated for FY 1985 and FY 1986. An explanation of the market basket used to develop the prospective payment rates was published in the **Federal Register** on September 1, 1983 (48 FR 39764). For additional background information on the market basket index, we refer the reader to the article by Freeland, Anderson, and Schendler, "National Hospital Input Price Index," *Health Care Financing Review,* Summer 1979, pp. 37–61.

The market basket is a Laspeyres or fixed-weight price index constructed in two steps. First, a base period is selected and the proportion of total expenditures accounted for by designated spending categories is calculated. These proportions are called cost or expenditure weights. In the second step, a rate of increase for each spending category is multiplied by the expenditure weight for that category. The sum of these products for all cost categories yields the percentage change in the market basket, an estimate of price change for a fixed quantity of purchased goods and services.

The market basket is described as a fixed-weight index because it answers the question of how much more it would cost at a later time to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services purchased subsequent to the base period are not considered. For example, shifts in the furnishing of a certain type of inpatient care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital but would not be factored into the market basket.

The market basket that is currently in effect reflects base-year data from 1977 in the construction of the cost weights. In its April 1, 1985 report to the Secretary (described in Appendix C of our June 10, 1985 proposed FY 1986 prospective payment update (50 FR 24446)), ProPAC suggested that the market basket cost weights should be recalculated or "rebased" at least every five years or more frequently if significant changes in the weights occur.

We agree that it is desirable to rebase the market basket cost weights periodically in order to reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) in furnishing inpatient care. The five-year interval that ProPAC recommended coincides with the frequency of a survey conducted by the Department of Commerce, Bureau of Economic Analysis, on industry input consumption. This survey, most recently described in the report, "The Detailed Input-Output Structure of the U.S. Economy, 1977", contains a detailed source of information on hospital input expenditures. In the September 3, 1985 final rule (50 FR 35684), we stated that we were in the process of developing rebased market basket cost weights that would reflect later data. We also stated that we would consider revising the market basket cost weights if additional costs, such as capital-related costs, were incorporated into the prospective payment system.

B. Rebasing and Reweighting the Market Basket Index

In this rule we are proposing to use a revised market basket in developing the FY 1987 update factor of the prospective payment rates. The new market basket would be revised as follows:

• We would rebase to reflect 1982, rather than 1977, cost data.

• We would expand the number of market basket cost categories from 14 to 32.

• We would add four categories for capital-related costs.

• We would modify certain variables used as the price proxies for some of the cost categories.

In developing the revised market basket, we reviewed hospital expenditures for the market basket cost categories. Preliminary data on hospital expenditures for the seven major operating expense categories (wages and salaries, employee benefits, professional fees and contracted nurses, depreciation, interest, utilities, and a residual "all other" category) were collected using 1982 data on Medicare participating hospitals from the 1983 AHA's Annual Survey. The AHA data include capital-related expenditures. No adjustments were made for hospitals with missing or AHA-inputed values. We then determined, for each category, the proportion it represents of total inpatient cost. These proportions represent the revised market basket weights. This approach is consistent with the way those values were calculated in 1979 using 1977 data. AHA's Hospital Administrative Survey provided the weight for malpractice insurance premiums that, although a median value, approximates the average

derived from an analysis of malpractice premium cost data using preliminary Medicare cost report data. Weights for the sub-categories within the residual category less malpractice, and other capital-related items, and for sub-categories within utilities were derived by projecting forward the U.S. Department of Commerce, Bureau of Economic Analysis' 1977 Hospital input and output data to 1982 using appropriate price proxies.

This work resulted in the identification of 32 separate cost categories in the rebased market basket. The differences between these categories and the ones used for the current 1977 based categories are summarized in the table below, and are as follows:

- Capital-related items (that is, depreciation split into fixed and movable equipment, interest, and other capital-related) were determined.
- Motor gasoline was disaggregated under utilities.
- Photographic supplies, paper products, minor machinery and equipment, miscellaneous equipment, computer data processing services, telephone, blood services, postage, and all other labor-intensive services and nonlabor-intensive services were made explicit under "all other products and services." A more detailed description of each category and respective price proxy is provided in Appendix A of this document.

TABLE A.—COMPARISON OF 1977 AND 1982 REBASED WEIGHTS AND COST CATEGORIES, INCLUDING CAPITAL

Expense categories	1977 market basket weights	Rebased 1982 market basket weights excluding capital	Rebased 1982 market basket weights including capital
1. Wages and salaries[1]	57.24	55.83	51.75
2. Employee benefits	8.22	9.80	9.08
3. Other professional fees	0.59	0.76	.70
4. Capital			7.32
a. Depreciation			4.16
(1) Fixed equipment			3.07
(2) Movable equipment			1.09
b. Interest			2.42
c. Other			.74
5. Energy and utilities	2.76	3.16	2.94
a. Fuel oil, coal, and other fuel	1.07	1.15	1.07
b. Electricity	0.77	1.09	1.01
c. Natural Gas	0.57	0.47	0.44
d. Motor gasoline		[2] 0.42	0.39
e. Water and sewage	0.35	0.03	0.03
6. Malpractice insurance	1.96	0.66	0.61
7. All other	29.23	29.79	27.60
All other products		21.05	19.50
a. Pharmaceuticals	2.82	4.10	3.80
b. Food	3.56	3.56	3.30
(1) Contract service	1.78	2.27	2.10
(2) Direct purchase	1.78	1.29	1.20
c. Chemicals and cleaning products	2.15	3.13	2.90
d. Surgical and medical instruments	2.03	2.38	2.20
e. Photographic supplies		[3] 2.26	2.10
f. Rubber and plastics	1.84	2.16	2.00
g. Paper products		[3] 1.19	1.10
h. Apparel	1.65	1.08	1.00
i. Minor machinery equipment		[3] 0.43	0.40
j. Miscellaneous products		[3] 0.76	0.70
All other services		8.74	8.10
a. Business services	4.70	3.02	2.80
b. Computer and data processing		[4] 1.40	1.30
c. Transportation and shipping	1.72	1.08	1.00
d. Telephone		[4] 0.76	0.70
e. Blood services		[3] 0.54	0.50
f. Postage		[3] 0.32	0.30
g. All other services: Labor intensive		[4] 0.97	0.90
h. All other services: Non-labor intensive		[3] 0.65	0.60
All other miscellaneous	8.76		

[1] In the rebased market basket, wages and salaries are composed of nine subcategories that correspond with the Employment Cost Index categories (Professionals and technicians, Managers, Sales, Clerical workers, Craft and kindred, Operatives except transport, Transport equipment operatives, Nonfarm laborers, and Service workers).
[2] This category was formerly incorporated into the original category—Fuel Oil, Coal, and Other Fuel.
[3] These categories were formerly incorporated into the original residual category, "All Other Miscellaneous."
[4] These categories were formerly incorporated into the original Business Services Category.

As shown in the table, the weights for a number of cost categories (current categories) declined from their 1977 level; namely, those weights for wages and salaries, malpractice insurance premiums, food at later stages of distribution, natural gas, water and sewerage, business services, transportation and shipping, and apparel. Weights for all the other categories increased.

The market basket weights published on September 1, 1983 (48 FR 39845) incorporate 1977 base-year cost-weights that were combined with differences in the rate of price proxy movements through 1981 to reflect their "relative importance" as a result of price changes in each variable. We have similarly adjusted the 1982 market basket cost weights shown above to reflect forecasted inflation through calendar year 1986. The 1986 relative importance weights for the rebased market basket cost categories are shown in Table 2 of section IV of the addendum.

In the September 1, 1983 interim final rule, for purposes of determining the labor-related portion of the standardized amounts, we summed the percentages of the labor-related items (that is, wages and salaries, employee benefits, professional fees, business services, and miscellaneous items) in the market basket (48 FR 39765). This summation resulted in a labor-related portion of the market basket of 79.15 percent and a nonlabor-related portion of 20.85 percent.

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act require that, in making payments under the prospective payment system, the Secretary adjust the proportion (as estimated by the Secretary from time to time) of payments that are wage-related. Since the inception of the prospective payment system, we have considered 79.15 percent of costs to be labor-related. This percentage was derived by adding the 1981 relative importance weights of those categories from the hospital market basket that were considered labor-related (see 48 FR 39765 for a further explanation).

In connection with the rebasing and reweighting of the hospital market basket we have, under the authority of the applicable section of the statute cited above, re-estimated the labor-related share of the standardized amounts. Based on the relative weights (excluding capital) described in Table 2 of section IV of the addendum, the labor-related portion (based on wages and salaries, employee benefits, professional fees, business services, computer and data processing, blood services, postage, and all other labor-intensive services) would be 75.04 percent (and therefore subject to the hospital wage index adjustment) and the nonlabor-related portion would be 24.96 percent. To implement this change, effective with discharges occurring on or after October 1, 1986, we recomputed the labor-related and nonlabor-related shares of each hospital's base year costs used to establish the prospective payment rates, and then followed the procedures discussed in the September 1, 1983 interim final rule in order to obtain revised labor-related and nonlabor-related standardized amounts (see 48 *FR* 39765–39768).

The restandardized amounts in Table 1 of section IV of the addendum reflect the revised labor-related and nonlabor-related portions. It should be noted that, because of the revision of the labor and nonlabor proportions, the labor portions of the rates published in Table 1 of this proposed rule have decreased from those published in the May 6, 1986 interim final rule (51 FR 16778), even though they reflect the increase of 0.5 percent. Similarly, the nonlabor portions in Table 1 have increased more than 0.5 percent because they now are based on a nonlabor proportion which is greater than the nonlabor proportion reflected in the rates published on May 6, 1986.

C. Selection of Price Proxies

After the 1982 cost weights for the rebased market basket were computed, it was necessary to select appropriate wage and price proxies to monitor the rate of increase for each expenditure category. Most of the indicators are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following four BLS categories:

- *Producer price indexes*—Producer price indexes are used to measure price changes for goods sold in other than retail markets. They are the preferable proxies for goods that hospitals purchase as inputs as part of the process in producing their outputs. These indexes, which are fixed-weight, measure "price" change at the producer or intermediate stage of production.
- *Consumer price indexes*—Consumer price indexes measure change in the prices of final goods and services bought by the typical consumer. Similar to the producer price indexes, they are fixed-weighted. Because they do not represent the price faced by the producers, the consumer price indexes were used if no appropriate producer price index was available, or if the expenditure was more similar to that of retail consumers in general, rather than a purchase at the wholesale level.
- *Employment cost indexes*—Employment cost indexes measure the rate of change in employee wage rates per hour worked. These indexes are fixed-weight indexes and thus measure strictly the change in wage rate and are not affected by shifts in employment mix.
- *Average hourly earnings indexes*—Average hourly earnings indexes are used to weight the hourly earnings for various occupations within a given industry and, therefore, reflect a weighted employment mix for a particular industry. The average hourly earnings index series is calculated by dividing gross payrolls by total hours, and measures actual earnings rather than wage rates. It is a current-weight rather than a fixed-weight index, and thus reflects shifts in employment mix.

Our proposed price proxies for the rebased prospective payment system market basket are summarized in Table II of the addendum. For a more detailed explanation of each of the price proxies, we refer the reader to Appendix A of this document. However, because we are proposing to revise the price proxy substantially for the wages and salaries category (the highest-weighted category) of the market basket based on a model developed by HCFA, we are providing a separate discussion of the new price proxy for the wages and salaries portion of the rebased market basket. For purposes of this discussion, we refer to the revised wages and salaries price proxy as the HCFA hospital occupational index.

D. The HCFA Hospital Occupational Index

Wages and salaries represent the largest single component of the hospital market basket, accounting for 52 percent of overall inpatient costs. Currently, the market basket increases in hospital wages and salaries are measured by using the average hourly earnings index for the hospital industry (Standard Industrial Classification 806), a data series collected by BLS.

In its April 1, 1985 report to the Secretary, ProPAC observed (in Recommendation Nos. 4 through 6) that the average hourly earnings series do not separate changes in inflation from changes in the mix of hospital workers over time. That is, rapid increases in average hourly wages could reflect changes in skill mix instead of in wage rates. ProPAC also expressed concern that HCFA's use of a price change measure specific to the hospital industry for the wages and salaries category allows hospital behavior to unduly influence increases in the market basket. For example, if the average hourly earnings series rises at a relatively high rate (as it did under the cost-based reimbursement system prior to the prospective payment system), exclusive use of a hospital industry series would permit hospitals to increase wages at a faster rate than other industries, even when unwarranted. Conversely, if growth in hospital wages and salaries is slower compared to other industries (such as in response to the prospective payment system or other incentives for cost containment), the market basket would reflect this behavior, and could provide an incentive for restricting wage increases for hospital employees.

To address these concerns, ProPAC recommended that separate wage and salary categories for occupational groups should be created to take into account the broad changes in skill mix among managers, professionals, and other hospital workers. ProPAC suggested that changes in wages for these categories should be measured using a combination of internal and external proxies as follows:

- Managers and Administrators—Employment cost index.
- Professionals and Technicians—A 50–50 blend of the average hourly earnings for the hospital industry and the employment cost index for professionals and technicians.
- Other Hospital Workers—A 50–50 blend of the average hourly earnings for the hospital industry and the employment cost index for all private industries.

The issue of whether to use only an internal wage proxy (that is, one based exclusively on hospital wage and salary data), or a combination of internal and external (hospital and nonhospital) wage proxies, has been debated for some time. It is generally accepted that prices for most nonlabor hospital inputs are nondiscretionary or beyond the control of the hospital industry. To monitor price changes in these expenditure categories, external prices are used. Hospital wages and salaries, however, should not be considered totally beyond industry control since there are employee categories for which hospitals are the principal employer (for example, registered nurses).

By classifying hospital wages and salaries into specific broad-based occupational categories, it is possible to group wages and salaries into two groups, those for which an internal proxy is more appropriate, and those for which an external proxy is more appropriate. We believe we are refining ProPAC's recommendation by further disaggregating the mix of hospital workers into specific categories, and applying a combination of internal and external price proxies in the HCFA hospital occupational index.

HCFA's hospital occupational index groups hospital occupations into nine broad categories. For eight of these occupational groupings, we believe that hospitals compete for labor generally with employers outside the health sector. Accordingly, use of an employment cost index as an external price proxy for each occupation seems most appropriate. In the case of nurses' wages, especially those of registered nurses, as well as certain other health care technicians and professionals, the hospital market predominates, and this should be reflected in the use of an internal wage proxy. However, hospitals also compete with other industries to obtain certain other skilled professional and technical staff (for example, computer programmers). Therefore, for professional and technical workers, we believe a price proxy that reflects a 50–50 blend of internal and external wage increases is appropriate. The proxy for the wages and salaries component of the prospective payment system market basket reflects internal and external measures of price changes as follows:

HCFA HOSPITAL OCCUPATIONAL INDEX

Wages/salaries component 1982 market basket index	Wages/ salaries percentage	Wage proxy
1. Professionals and technicians.	57.24	50-50 blend of: Average Hourly Earnings (Standard Industrial Classification (SIC) code 806) for nonsupervisory hospital workers; and employment cost index, wages and salaries, for professionals and technicians.
2. Managers	7.25	Employment cost index, wages and salaries, for managers and administrators.
3. Sales	.34	Employment cost index, wages and salaries, for sales workers.
4. Clerical workers	12.54	Employment cost index, wages and salaries, for clerical workers.
5. Craft and kindred	2.46	Employment cost index, wages and salaries, for craft and kindred workers.
6. Operatives except transport.	.99	Employment cost index, wages and salaries, for operatives except transport.
7. Transport equipment operatives.	.26	Employment cost index, wages and salaries, for transport equipment operatives.
8. Nonfarm laborers	.20	Employment cost index, wages and salaries, for nonfarm laborers.
9. Service workers	18.72	Employment cost index, wages and salaries, for service workers.
10. Total wages	100.00	Total weight for wages is 51.75.

We believe that the HCFA hospital occupational index would provide a more accurate and equitable basis for monitoring increases in the wages and salaries portion of the market basket, and that it responds to ProPAC's concern that the market basket should reflect labor market forces that are both internal and external to the hospital industry.

IV. Other Decisions and Proposed Changes to the Regulations

A. Elimination of Periodic Interim Payments (§ 405.454)

1. Background

Prior to implementation of the prospective payment system, all providers were reimbursed based on the lesser of the reasonable cost of services furnished to Medicare beneficiaries or the provider's customary charges for those services. Prospective payment hospitals currently continue to be reimbursed based on reasonable cost for certain expenses such as training nurses and allied health personnel. In addition, hospitals and hospital units excluded from the prospective payment system and most other providers are still reimbursed on the basis of reasonable cost.

Since actual reasonable cost cannot be determined until the end of a provider's cost reporting period, an interim rate, approximating actual cost as closely as possible, is determined by the intermediaries for each provider and interim payments are made during the year. These interim payments are required by section 1815(a) of the Act, which states that we must pay providers at least monthly during the cost reporting period, pending a final determination of cost on the basis of a submitted cost report and any necessary adjustments. The regulations that implement these policies are located at § 405.454. After receipt of the provider's cost report, the intermediary determines what the actual reimbursement for the period should have been and a retroactive adjustment is made.

There are two methods of interim reimbursement for inpatient hospital services for hospitals excluded from the prospective payment system. One method is based on actual bills submitted by the hospital. Under this method interim payments are calculated by applying a predetermined per diem amount to the number of days reflected on actual bills or by applying a predetermined percentage to the charges reflected on the actual bills submitted. The predetermined per diem amount or percentage factor applied to billed patient days or charges represents an estimate of the hospital's costs that will be incurred.

Under the second method, referred to as the periodic interim payment (PIP) method, interim payments are not based on individual bills. Instead, payment is based on the estimated annual costs attributable to estimated Medicare utilization of a hospital, and equal biweekly payments are made to hospitals without regard to the submission of individual bills. PIP has been available for inpatient hospital services since 1968. It was offered to qualified hospitals as an alternative to regular interim reimbursement, which requires submission of a bill to receive payment.

With either of these interim payment methods, any overestimation or underestimation of the hospital's actual costs, to the extent not adjusted during the year, is adjusted at the time of cost report settlement.

For those items or services reimbursed on a reasonable cost basis, we make interim payments to providers throughout the year based on the reasonable cost of the item or services furnished to beneficiaries during the year. Although the PIP method of interim payment is not based on actual bills submitted, a PIP provider must continue to submit bills for subsequent intermediary verification of the accuracy of the rate, as well as recording an individual's benefit utilization. The rate is reviewed twice per year for hospitals paid under the prospective payment system and at least quarterly for hospitals reimbursed on a reasonable cost basis. If necessary, as determined by the reviews, the rate is adjusted. Interim payments may be further adjusted at year end based on submitted cost reports.

Under the prospective payment system, hospitals are paid, for most of the Part A inpatient services they furnish, a prospectively determined amount for each discharge based on actual bills submitted. This amount constitutes final payment for each discharge claimed. Although no form of interim payment is necessary for hospitals operating under the prospective payment system, we extended the option to these hospitals to elect to receive PIP when the prospective payment system was implemented in order to avoid cash flow problems. Thus, § 405.454(m) provides that hospitals that meet the qualifications for receiving PIP set forth in § 405.454(j) may elect to receive this type of interim payment, which would be based on their estimated annual prospective payment amounts. In these circumstances, year-end reconciliation is required.

Payment for capital-related items [1] and those direct medical education costs that are payable on a reasonable cost basis continue to require interim payments pending a year-end reconciliation based on a cost report. These interim payments are determined by estimating the reimbursable amount for the year based on the previous year's experience and on information for the current year and dividing that amount into 26 equal payments made biweekly. In addition, the indirect teaching adjustment, if appropriate, is paid on a biweekly interim basis subject to final settlement. Biweekly payment for these items is the method of interim reimbursement required by current regulations (§ 405.454). Since a hospital

[1] As discussed above in section II, we are proposing to incorporate payments for capital-related costs into the prospective payment system via a four-year phase-in period, effective with cost reporting periods beginning on or after October 1, 1986. Those portions of the hospital's capital payments that continue to be reimbursed on a hospital-specific basis would also continue to be paid on an interim payment basis.

has no option as to the payment method for these items, the payments are not considered as part of the PIP method of payment.

As indicated above, our primary reason for offering PIP to hospitals paid under the prospective payment system was to ensure that hospitals would not experience cash-flow problems as they made the transition from cost-based reimbursement to prospective payment. We believed that implementation of a payment system that was new to both hospitals and intermediaries might have, in some cases, cause fluctuation or temporary interruption in payments to hospitals. Therefore, PIP was made available to qualified hospitals to ease the problems inherent in this start-up period.

2. Problems With PIP

Evidence indicates that the PIP method has become an increasingly needless and time-consuming burden for the intermediaries and that it results in the expenditures of considerable resources in attempting to identify and correct overpayments and underpayments. For example, because this payment method does not rely initially on submitted bills, changes in a provider's utilization are not identified as quickly as under the regular interim reimbursement method.

Eliminating PIP for all hospitals, that is, those reimbursed on the basis of reasonable costs and those subject to prospective payment, would allow intermediaries to utilize their resources more effectively to better control payments to hospitals, and all other providers. Furthermore, the proposed elimination would encourage hospitals to submit their bills on a more timely basis. Hospitals receiving PIP have less incentive to bill timely than hospitals not receiving PIP. The latter hospitals are required to submit a bill before receiving any payment. Therefore, we are proposing to revise § 405.454 (j) and (m) to eliminate PIP for all hospitals effective with discharges occurring on or after July 1, 1987.

We recognize that some hospitals may be adversely affected by such a major change as the elimination of PIP. In order to minimize any cash flow problems that may arise, and to allow hospitals sufficient lead time to adjust their billing practices, we are proposing to eliminate PIP effective with discharges occurring on or after July 1, 1987. In addition, the impact on hospital cash flows can be alleviated through the availability of accelerated payments for those delays resulting from an intermediary's operation or, in unusual circumstances, a hospital's operation.

PIP represents a general departure from customary business practice because it is a payment system unrelated to submitted bills. Its elimination would allow us to control Medicare payments in a more efficient and business-like manner. We do not expect that hospitals would have much difficulty adjusting their payment operations, and as previously indicated in the case of unexpected delays, accelerated payments are available to hospitals.

While we believe that the elimination of PIP is a reasonable and practical measure to take for all hospitals, it is particularly so for those hospitals subject to the prospective payment system. Our main purpose for extending PIP to prospective payment hospitals, that is, to ensure that the new system would not cause cash flow problems while hospitals became acclimated to the new system, has been served. By July 1, 1987, almost all hospitals under the prospective payment system will have operated under that system for at least three full years. Furthermore, we believe that interim payments made to hospitals in an attempt to approximate final payments are not appropriate, as a continuing practice, under a system that provides for final payment upon discharge based on submission of a bill. The entire legislative history of the public laws on which the prospective payment system is based underlines congressional intent concerning the *prospectivity* of the new system. With respect to hospitals that are excluded from the prospective payment system and reimbursed on a cost basis, we do not believe that PIP continues to be appropriate. Not only has it become very difficult and time consuming for intermediaries to ensure that accurate interim payments are made to these hospitals using the PIP method, but also, over the years, we believe that hospitals have become very capable of submitting timely and accurate claims. Similarly, intermediaries are able to process claims without undue delays.

Under our proposal, we would make payment to hospitals, based on submitted bills for payment not less often than monthly.

3. Exceptions to the Elimination of PIP

In eliminating PIP, there is one problem that we believe we need to address. Some prospective payment hospitals, particularly small rural hospitals, have experienced serious cash-flow shortages because of the unusually long lengths of stay of some Medicare patients. Without PIP, these hospitals would experience difficulties in recouping their expenses on a timely basis, because bills cannot be submitted until after the patients are discharged. In order to alleviate the cash flow problems that these hospitals encounter, we are proposing a form of interim payment to accommodate these situations. We are proposing to allow hospitals subject to the prospective payment system to request this payment if a patient has been in the hospital more than 45 covered days.

For these cases, payment would be made at the rate for the DRG that results from applying the GROUPER classification to the diagnosis, procedures, and other pertinent information, that are reported on the interim bill. (GROUPER is the computerized screening process used to determine the appropriate DRG for each discharge under the prospective payment system. Only one interim payment would be made per discharge. Any interim payment made would be applied against the final payment made for the discharge. This change would also be effective for discharges occurring on or after July 1, 1987. We believe that the proposed amount of the interim payment represents a fair compromise between the interests of the Medicare program in adhering to the principle of prospectivity in the new payment system and the interests of those hospitals that could be adversely affected, in terms of cash flow, by the elimination of PIP.

In addition to eliminating PIP for hospitals reimbursed on the basis of reasonable costs and for prospective payment hospitals, we are also proposing to eliminate this method of interim payment for hospitals receiving payment under a demonstration project authorized by section 402(a) of the Social Security Amendments of 1967 (Pub. L. 90–248) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603). Also, we would extend this policy to those hospitals paid under State cost control systems authorized by sections 1814(b) or 1886(c) of the Act and approved by HCFA. However, these hospitals would be permitted to use a form of interim payment similar to PIP if that type of payment is specifically approved by HCFA. This might occur, for example, if that type of payment is considered to be an integral part of the demonstration or cost control system.

By definition, alternative payment systems authorized under the authorities described above provide for payments to be made on bases and methods that vary from those on which usual Medicare payment is made. For these systems, certain Medicare regulations and procedures may be waived

provided that, among other factors, payments made under the alternative payment systems will not exceed the amount of payments that would otherwise have been made by Medicare.

However, hospital demonstrations in general are designed to test new prospective-type payment methodologies. In addition, prospectivity is required for systems approved under the authority of section 1886(c)(5) of the Act. A main purpose of these prospective payment methodologies is to move away from traditional cost-based reimbursement that requires final settlement of costs at year end, a type of payment that by its very nature makes interim payment unnecessary. Instead, payment would be made based on submitted bills for payment not less often than monthly.

It is our opinion that interim payments for services payable on the basis of a prospectively determined rate are inconsistent with the purpose of a prospective payment system. Therefore, a prohibition against PIP for hospitals paid under the Medicare prospective system should not be waived for hospitals similarly receiving prospective payments under an alternative prospective system. However, we believe that an exception would be warranted if HCFA were satisfied with an alternative system in its entirety, including the integration of PIP-type payments as part of the total system. States that are interested in incorporating or retaining PIP as part of their alternative or demonstration methodology should address the necessity for this mechanism in light of the prospectivity requirements discussed above at the time of their application for approval or renewal of the system under the demonstration authority or section 1886(c) of the Act.

Payment for capital-related costs to the extent they are not included in operating costs, direct medical education and other inpatient hospital costs excluded from the prospective payment system would continue to be made biweekly on an interim payment basis under the provisions of §§ 405.454 (m)(3) and (m)(4).

4. Summary

In summary, we are proposing to revise § 405.454 to—

- Eliminate PIP for all hospitals effective with discharges occurring on or after July 1, 1987;
- Eliminate PIP for hospitals participating in demonstration projects or State cost control systems unless that type of payment is approved by HCFA as a part of the project or system; and
- Allow an interim payment to prospective payment hospitals for beneficiaries who remain in an inpatient status for more than 45 covered days.

B. Establishing a Base Period for Purposes of Determining the Rate-of-Increase Ceiling for Hospitals Excluded From the Prospective Payment System (§ 405.463)

Hospitals that are excluded from the prospective payment system and, at their option, cancer hospitals, are paid on a reasonable cost basis subject to the rate-of-increase ceilings under section 1886(b) of the Act and implementing regulations at § 405.463.

Section 405.463(b)(1) provides that each hospital's initial rate-of-increase ceiling will be based on allowable inpatient operating costs per case incurred—

- In the 12-month cost reporting period immediately preceding the first cost reporting period subject to the ceiling; or
- For short reporting periods (fewer than 12 months), the first 12-month period ending after October 1, 1982.

Concern was expressed as to the determination of the base period for hospitals excluded from the prospective payment system in States in which a demonstration project (sections 1814(b)(3) or 1886(c) of the Act) was terminating. We believe § 405.463(b)(1) should provide that each hospital's initial base period subject to the rate of increase ceiling is—

- The 12-month cost reporting period immediately preceding the first cost reporting period subject to the ceiling (for example, the base period would be January 1, 1985 through December 31, 1985 for a hospital paid under a demonstration project which terminates December 31, 1985); or
- Where the immediately preceding reporting period is a short cost reporting period (that is, less than 12 months), the base period will be the 12-month cost reporting period beginning on or after the date the hospital's exemption from the ceiling ends (for example, the base period would be the 12-month period beginning on or after January 1, 1986 for a hospital paid under a demonstration project which terminates December 31, 1985).

We are proposing to clarify § 405.463(b)(1) to correctly state the applicable base period initially subject to the rate-of-increase ceiling for hospitals with short cost reporting periods. We note that this revision would apply to both hospitals in a State with a demonstration project that is terminating (and for which the hospitals would continue to be excluded from the prospective payment system), and to hospitals which are no longer exempt from the ceiling as new providers (§ 405.463(f)(1)).

C. Extension of the Exclusion of Alcohol/Drug Hospitals and Units (§§ 412.23 and 412.32)

In the January 3, 1984 final rule, we developed a set of criteria for the exclusion of hospitals and distinct part units that specialize in alcohol/drug dependency treatment (49 FR 241). As provided in that rule under §§ 412.23(c) and 412.32, exclusion was to have terminated on October 1, 1985.

In the June 10, 1985 proposed rule, we proposed to revise §§ 412.23(c) and 412.32 to provide that the exclusion of hospitals and distinct part units that specialize in alcohol/drug dependency treatment would expire at the end of the hospital's cost reporting period that began before October 1, 1985 (50 FR 24387). We were also proposing simultaneously to reclassify and reweigh the alcohol and drug abuse DRGs (433 through 438) within the major diagnostic category (MDC) 20 (Substance Use and Substance Induced Organic Mental Disorders) to make an appropriate adjustment for alcohol/drug treatment services (50 FR 24370). However, in order to provide additional time to validate the newly constituted and weighted alcohol and drug abuse DRGs (433 through 437), we decided in the September 3, 1985 final rule to continue the exclusion for another year (that is, through cost reporting periods that began before October 1, 1986) pending further study and analysis (50 FR 35869).

The Department undertook a study to reabstract alcohol and drug abuse cases in order to validate the classification and weights of the DRGs. To date, the collection and analysis of survey data for the MDC 20 DRGs are not complete. Because we are unable definitively to assure the appropriateness of the alcohol and drug abuse DRGs, we have decided to further delay the end of the exclusion. We are continuing to gather and analyze the data to evaluate the new groupings we have developed. Until we have completed this study, we are proposing to review §§ 412.23(c) and 412.32 to extend the exclusion of alcohol/drug hospitals and units (that are currently excluded) for another year.

D. Hospitals in Redesignated Rural Counties Which Are Surrounded on All Sides by Urban Counties (§ 412.63)

Section 1886(d)(2)(D) of the Act requires that average standardized amounts per discharge be determined

for hospitals located in urban areas and rural areas of the nine census divisions and the nation. Under the prospective payment system, a hospital's payment rate is dependent, to some degree, on whether the county in which a hospital is located is designated as an urban area or as a rural area. The term "urban area" is defined as provided in section 1886(d)(2)(D) of the Act, in accordance with the Executive Office of Management and Budget's (EOMB's) designations, as a Metropolitan Statistical Area (MSA), a New England County Metropolitan Area (NECMA), or certain New England counties deemed to be urban areas under section 601(g) of Pub. L. 98–21 (42 U.S.C. 1395ww (note)). The term "rural area" means any area outside an urban area.

Section 1886(d)(8) of the Act, as added by section 2311(c) of Pub. L. 98–369, provides for an adjustment to the payment amounts for hospitals reclassified from urban to rural after April 20, 1983. Effective with hospital cost reporting periods beginning on or after October 1, 1983, a hospital that loses its urban status, as a result of an EOMB redesignation occurring after April 20, 1983, may qualify for special consideration by having its rural Federal rate phased in over a two-year period (§ 412.102).

Using our authority under section 1886(d)(5)(C)(iii) of the Act, to "provide by regulation for such other exceptions and adjustments" as are deemed appropriate, we are proposing to expand on the above provisions by recognizing the circumstances of a hospital located in a redesignated rural county that is surrounded on all sides by urban counties. Given the unique situation of such a hospital, we believe special consideration is warranted in order to ensure equitable treatment under the prospective payment system.

Therefore, effective with discharges occurring on or after October 1, 1986 we are proposing to consider a hospital as urban, for prospective payment purposes, if it meets all of the following criteria:

- The rural county in which the hospital is located must be surrounded on all sides by urban counties.
- The county in which the hospital is located was reclassified from an urban area to a rural area after April 20, 1983 (the date of enactment of Pub. L. 98–21).
- Based on the latest census data, at least 15 percent of employed workers in the county in which the hospital is located commute to the central county or counties of one of the adjacent areas. The term "central county," as defined by EOMB, is based on commuting patterns of employed workers. The 15 percent minimum commuting criterion is intended to establish the county's economic interaction with at least one of the adjacent MSAs. Given the fact that a county which is surrounded by a number of MSAs would likely interact economically, to some extent, with more than one urban area, we believe the minimum required commuting rate to one urban area should be low enough to account for this situation.

Hospitals that meet these criteria would be deemed urban for purposes of computing prospective payments, and would be reclassified into the MSA or NECMA in which it had been previously designated prior to the EOMB redesignation. We would revise § 412.63(b) to implement this provision.

We have identified one hospital located in Shiawassee County, Michigan that would qualify for special treatment under these provisions. Accordingly, that hospital located in Shiawassee County, Michigan would be reclassified into the Flint, Michigan MSA where it had been previously designated. (We note that Shiawassee County also had the highest commuting rate to the Flint MSA.) For wage index purposes, we would also consider Shiawassee County to be part of the Flint, Michigan MSA (see Table 4a of the addendum), and have recomputed the wage index to reflect this change.

As a matter of policy, we believe it is appropriate to adjust the standardized amounts in such a case. However, we are assessing the administrative implications of making such adjustments for purposes of this limited exception. Because we have not completed our assessment of administrative implications, we have not adjusted the standardized amounts in this proposed rule.

E. Referral Centers (§ 412.96)

In the August 31, 1984 final rule, we added an alternative set of criteria to § 412.96 (then § 405.476(g)) that expanded the definition of referral centers to encompass more rural hospitals. We also added a new paragraph to that section that provides for a triennial review of referral centers to determine if they continue to meet the criteria for a referral center. (See 49 FR 34740 for a detailed discussion of those revisions.) Under those alternative criteria, in order to qualify as a referral center, a hospital must meet two mandatory critiera (number of discharges and case-mix index) and at least one of three optional criteria (medical staff, source of inpatients, or volume of referrals), in addition to being located in a rural area.

1. Number of Discharges

The number of discharges criterion measures whether the hospital has a comparatively high number of cases. We established this criterion because virtually all discussions of rural referral centers in the legislative history contain references to "large hospitals," "very large acute care hospitals," and "large referral hospitals located in rural States." (129 Cong. Rec. S3224–26 (daily ed. Mar. 17, 1983)) Thus, in establishing the criteria to define rural referral centers, we included a standard to differentiate these larger facilities from rural hospitals of average size.

In the August 31, 1984 final rule (49 FR 34761), we set forth in § 412.96 (then § 405.476(g)) four different discharge criteria, one of which a hospital must meet, along with other criteria, in order to qualify as a referral center for cost reporting periods beginning on or after October 1, 1984. A hospital's number of discharges (excluding discharges from subprovider units) had to be at least equal to—

- 6,000 for the hospital's cost reporting period that ended in 1981;
- 6,000 for the hospital's most recently completed cost reporting period;
- The median number of discharges of urban hospitals for cost reporting periods ending in 1981 for the region in which the hospital is located for the hospital's cost reporting period that ended in 1981; or
- The median number of discharges of urban hospitals for cost reporting periods ending in 1981 for the region in which the hospital is located for the hospital's most recently completed cost reporting period.

In the September 3, 1985 final rule (50 FR 35689), we eliminated the two options that related to a hospital's number of discharges for its cost reporting period that ended in 1981. We did not believe that 1981 discharge data were relevant to a hospital's qualification for rural referral center status five or more years later. The two remaining options relate directly to the number of discharges in a hospital's most recently completed cost reporting period.

In addition, we did not update the 6,000 figure for number of discharges (the national value) in the September 3, 1985 final rule (50 FR 35675) because our discharge data for 1984 were incomplete and because it was not clear that hospitals serving as referral centers would have experienced the same decline in discharges as the nation as a whole. However, we believe that the number of discharges criterion should be

updated in this year's prospective payment notice because we believe that hospitals serving as referral centers have experienced a reduction in discharges similar to all other hospitals. These data reflect changes that have occurred since 1981, the year from which the initial discharge criteria were derived.

We are proposing to update the number of discharges criteria effective with cost reporting periods beginning on or after October 1, 1986. These proposed values are updated using the most current data available on discharges. We believe that it is necessary to update these values not only to enable new hospitals to qualify as referral centers, but also to provide current criteria against which existing referral centers can be measured during their triennial review to determine if they continue to qualify for special treatment on the basis of their number of discharges. We are also proposing to revise § 412.96 to describe the process we would use to calculate the number of discharges. The actual national and regional values would set forth in each year's annual notice of prospective payment rates as is currently required under § 412.96(c)(2).

To determine the change in the national and regional number of discharge values, we would use American Hospital Association (AHA) panel survey data available for the most recently completed fiscal year. We would compare the discharges from non-Federal short-term acute care general hospitals in that period to discharges in 1981. The percentage change (increase or decrease) would be used to update the 6000-discharge standard. The updated national and regional values would be effective for a hospital's most recently completed cost reporting period prior to the period for which it is applying for referral center status or for the period for which an existing referral center is being reviewed.

For both the national and regional discharge values, we reduced the 1981 standards as noted in the September 3, 1985 final rule (50 FR 35675–76) by 8.05 percent to reflect the national percentage change in the number of discharges from the year ending in September 1981 through the year ending in September 1985. The percentage is calculated from AHA panel survey data, which show that there were 37,840,267 admissions [1] to community hospitals [2] in FY 1981 and 34,793,931 admissions to community hospitals in FY 1985, an 8.05 percent decrease. Thus, the proposed national number of discharges criterion is computed by multiplying the 1981 discharge standard by .9195 (100.00 − 8.05=91.95), as follows:

6,000 times .9195=5,517

The same method (and percentage value of 8.05) is used to reduce each 1981 regional median urban discharge value.

Therefore, in addition to meeting other criteria, we are proposing that to qualify as a referral center or for purposes of the triennial review to retain rural referral center status, for cost reporting periods beginning on or after October 1, 1986, a hospital's number of discharges for its most recently completed cost reporting period would have to be at least—

- 5,517; or
- Equal to the median number of discharges for urban areas calculated by HCFA for the census region in which the hospital is located as indicated in the table below.

	Median urban discharges
Region:	
1	6,866
2	7,909
3	7,158
4	8,560
5	7,659
6	7,830
7	5,414
8	9,129
9	5,116

In addition, section 9106 of Pub. L. 99–272 amended section 1886(d)(5)(C)(i) of the Act to permit rural osteopathic hospitals to qualify for the rural referral center adjustment if they meet the case-mix index standard, one of the optional criteria, and if they have at least 3,000 discharges annually. This provision would apply to cost reporting periods beginning on or after January 1, 1986. Because of the small number of osteopathic hospitals, we are proposing not to establish regional standards under this provision. The 3,000 discharges figure would apply to all rural osteopathic hospitals nationwide and, for purposes of rural referral center recognition only, would apply to rural osteopathic hospitals recognized by the American Osteopathic Hospital Association.

We are proposing to revise § 412.96 to implement the provision for rural osteopathic hospitals in section 9106 of Pub. L. 99–272.

2. Case Mix Index

Section 412.96(c)(1) provides that HCFA will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining referral center status. In the September 3, 1985 final rule (50 FR 35676), we calculated the national case-mix criterion as follows:

$$\frac{1.03 \times 1.108}{1.0105} = 1.1294$$

in which:

- 1.03 represented the 1981 case-mix index benchmark for complexity of cases treated in a facility;
- 1.108 represented the increase (10.8 percent) in the national average case-mix index since 1981, for discharges through the midpoint of the Federal fiscal year; and
- 1.0105 represented the reduction in the DRG relative weights for discharges occurring on or after October 1, 1984. (See the August 31, 1984 final rule (49 FR 34770).)

We used the same formula applied to each region's 1981 urban median case-mix value in determining the updated urban median case-mix values for FY 1986.

On the basis of hospital bills received in HCFA through March 1986, we have determined that the national average case-mix index has increased by 15.4 percent since 1981.

Using the same formula and currently available program data indicating a 15.4 percent increase in the national average case-mix index since 1981, we are proposing to update the national case-mix criterion as follows:

$$\frac{1.03 \times 1.154}{1.0105} = 1.1763$$

[1] Although the AHA data are based on the number of admissions, we believe that, in the aggregate, there is little, if any, difference between the number of admissions and the number of discharges over the course of a year.

[2] The term "community hospitals" encompasses, for the most part, hospitals subject to the prospective payment system. For purposes of the panel survey data, AHA defines community hospitals to be all non-Federal, short-term general and other special hospitals, excluding hospital units of other institutions, whose facilities and services are available to the public. Noncommunity hospitals are defined as Federal hospitals, long-term hospitals, hospital units of other institutions, psychiatric hospitals, hospitals for tuberculosis and other respiratory diseases, chronic disease hospitals, institutions for the mentally retarded, and alcoholism and chemical-dependency hospitals.

The same method (and percentage value of 15.4) is used to increase each 1981 regional median urban case-mix value.

Therefore, in addition to meeting other criteria, we are proposing that to qualify as a referral center, or for purposes of the triennial review for retention of referral center status, for cost reporting periods beginning on or after October 1, 1986, a hospital's case-mix index for the Federal fiscal year ending September 30, 1986 would have to be at least—

- 1.1763; or
- Equal to the median case-mix index for urban areas calculated by HCFA for the census region in which the hospital is located as indicated in the table below.

Region	Adjusted urban median case-mix
1	1.2048
2	1.2230
3	1.1820
4	1.1945
5	1.1534
6	1.1671
7	1.1100
8	1.2060
9	1.2254

The above numbers will be revised in the final rule to this proposed rule to the extent that additional bills are received for discharges through March 1986.

F. Changes to DRG Classifications and Weighting Factors

Under the prospective payment system, we pay for inpatient hospital services on the basis of a rate per discharge that varies by the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case takes an individual hospital's payment rate per case (comprised of a hospital-specific portion and an urban or rural Federal portion adjusted for area wages) and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average required to care for cases in that particular DRG relative to the national average resources consumed per case by the average hospital. Thus, cases in a DRG with a weight of 2.0 would, on average, require twice as many resources as the average case for the average hospital.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resources consumption. In addition, Congress provided the Secretary with authority to reclassify services and procedures within the DRG system to take into account changes in medical technology and treatment patterns. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments are made to reflect changes in resource consumption, treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The intention of Congress was that we would make changes as often as needed to achieve the objectives of the prospective payment system, including the need to keep current with developments in the areas of coverage and medical technology. The proposed DRG reclassifications for discharges occurring on or after October 1, 1986 are set forth below.

The method of classifying cases into DRGs for payment under the prospective payment system involves a number of steps. The intermediary enters medical and other information contained in each patient's bill into its claims systems and subjects it to a series of automated screens called the Medicare Code Editor. These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the Medicare Code Editor and any further development of the claims, cases are classified by GROUPER into the appropriate DRG. The GROUPER software program was developed as a means of classifying each case into the appropriate DRG on the basis of the diagnosis and procedure codes and demographic information, that is, sex, age, and discharge status. It is used both to classify past cases in order to establish the DRG weights and to classify current cases for payment.

During the initial operating period of the prospective payment system, we learned that the use of the DRG method of classification posed some operational challenges that we needed to address further. We issued a notice on March 13, 1986 (51 FR 8762) to propose a number of improvements to the DRG classification system and finalized the proposal elsewhere in this edition of the **Federal Register**. We will reflect those changes in a revised GROUPER program to be effective with discharges occurring on or after October 1, 1986.

Although we originally intended to limit modifications of the DRG classification system to a single annual notice, we have found that, at least for this year, such a practice is not appropriate. In response to the public's request, we proposed DRG changes early in the calendar year (March 13, 1986). However, ProPAC has made several recommendations concerning additional DRG classification changes. These recommendations were not presented until after publication of our proposed changes. Some of ProPAC's recommendations have merit and represent analysis of data that was not available to us or problems that were not raised to us. We do not believe it is appropriate to delay recognition of ProPAC's suggested changes on DRG classification issues until our next annual publication of classification changes simply because its report was made subsequent to our proposed changes. To do so would unnecessarily delay implementation of improvements to the system. Consequently, we are proposing to revise the reference to an annual notice in § 412.10(a), and to go forward with a second notice of proposed DRG classification changes that are included in this document.

We continue to believe it would be most beneficial to the industry to strive toward a single annual notice of DRG changes. We also believe it is appropriate to propose such changes prior to the proposed rule on prospective payment system changes required each June. We will attempt to work with ProPAC more closely in the future with a goal of better coordinating our efforts in this area so that we may eventually achieve a single annual notice of DRG classification changes.

1. DRG Logic Issues—DRG 385

We have been advised that it is common practice in hospitals to report the discharge status of a newborn discharged to foster care as "transfer-other". The GROUPER program assigns all newborns to a distinct DRG (DRG 385) if the discharge status is reported as "died or transferred", regardless of the type of transfer cited.

The intent of DRG 385 is to establish a unique classification for acutely ill newborns. We do not believe it is appropriate to use this classification for normal newborns simply because they were discharged to foster care. Consequently, we are proposing to revise the GROUPER logic for DRG 385 so that only cases with reported discharge status of died or transferred to an acute care hospital will be classified to this DRG. All other discharges for newborns would be classified into the appropriate DRGs (DRGs 386–391) within major diagnostic category (MDC) 15 based on their diagnosis and procedure codes. Since this is a low volume procedure for Medicare purposes, this classification change will not result in a change in the DRG

weighting factor, but would only affect future classification of cases to this DRG.

2. Burns

Throughout the past year we have received numerous letters advising us of difficulty with the classification of burn cases. ProPAC also has studied this issue, although it did not make a formal recommendation on this matter. (See Technical Appendixes to ProPAC's April 1, 1986 Report to the Secretary, pages 124–133.)

There appear to be numerous factors contributing to the high heterogeneity of the burn DRGs, and we agree with ProPAC that additional evaluation of MDC 22 (Burns) is necessary. However, we have found that significant improvement in the homogeneity of DRG 457, Extensive burns, can be achieved by further classifying extensive burn cases based on operating room procedures. Consequently, we are proposing to establish a new DRG for MDC 22. We are proposing to create DRG 472, Extensive burns with operating room procedure, that would include cases with a principal or secondary diagnosis of extensive burns (those currently classified in DRG 457) and any of the operating room procedures currently classified in DRGs 458, Non-extensive burns with skin grafts, and 459, Non-extensive burns with wound debridement and other operating room procedure. DRG 457 would be modified to specify this classification includes extensive burns without operating room procedure.

We will continue to study classification of cases in MDC 22. If we find further changes in this MDC are necessary, they will be proposed in a future DRG classification notice.

3. Surgical Hierarchy

Review of claims data and DRG relative weighting factors for DRGs has led us to conclude that revision of the surgical hierarchy of several MDCs is necessary. For the most part, the present hierarchy is based on clinical judgment and aged resource data. We have found that in some cases, the present hierarchy results in classification of cases with multiple surgical procedures to lower weighted DRGs because a less resource-intensive procedure is higher up in the hierarchy than another more resource-intensive procedure. Changes in practice patterns and technology have occurred since the surgical hierarchy was developed. The recalibration of the DRGs using FY 1984 claims data indicates current resource utilization for certain classes of surgical procedures is somewhat different than was common when the surgical hierarchy was developed.

We believe that cases showing multiple surgical procedures should be classified into the DRG that coincides with the most resource intensive procedure performed. Therefore, we are proposing to reorder the surgical hierarchy for MDCs 2, 3, 5, 6, 7, and 21 as set forth below:

MDC 2—Extraocular Procedures Except Orbit would be placed above Primary Iris Procedures.

MDC 3—Cleft Lip and Palate Repair and, Sinus and Mastoid Procedures (in that order) would be placed above Salivary Gland Procedures Except Sailoadenectomy.

MDC 5—Permanent Cardiac Pacemaker Implantation would be placed above Vascular Procedures.

MDC 6—Mouth procedures would be placed above Anal and Stomal Procedures.

MDC 7—Diagnostic Procedures would be placed above Biliary Tract.

MDC 21—Wound Debridements would be placed above Skin Grafts.

All of the changes discussed above, if adopted in the final rule to follow this proposed notice, would also be incorporated in the revised GROUPER program for FY 1987. In addition, the reclassifications would affect the weights of the DRGs from which and to which cases are being moved. We have estimated the revised weights wherever possible and reflected those estimated weights in the addendum to this proposed rule (Table 5).

However, because changes in the surgical hierarchy alter the order in which the GROUPER searches for surgical procedures upon which to base DRG assignments, the effects of the proposed surgical hierarchy changes could not be estimated, as the GROUPER must be entirely reprogrammed to incorporate the hierarchy changes. Since the proposed hierarchy changes are based on the fact that the current relative weights for DRGs in certain sections of the hierarchy are greater than the relative weights for DRGs higher up in the surgical hierarchy, adoption of the proposed surgical hierarchy changes should yield more homogeneous DRGs where multiple procedures are involved and currently result in assignment to a lower-weighted DRG than would occur if only the more resource-intensive procedure was performed. The following table lists the DRGs whose weights may be affected by the proposed surgical hierarchy change in each MDC:

MDC 2—DRGs 38, 40 and 41

MDC 3—DRGs 51, 52, 53 and 54

MDC 5—DRGs 108, 110, 111, 112, 115 and 116

MDC 6—DRGs 157, 158, 168 and 169

MDC 7—DRGs 193, 194, 195, 196, 197, 198, 199 and 200

MDC 21—DRGs 439 and 440

The revised GROUPER will permit us to re-group Medicare cases from the FY 1984 Part A Tape Bill (PATBILL) file in accordance with the manner in which they would be grouped for payment purposes beginning October 1, 1986. Accordingly, we propose to reweight the DRGs in the final rule so as to ensure that the reclassifications adopted result in neither increases nor decreases in aggregate Medicare payments. Reweighting is distinguished from recalibration in that it involves use of the same data base as was used for the weights currently in place, whereas recalibration entails the use of a different, more recent data base. Because reweighting is otherwise identical to recalibration, we note that the weights for DRGs in which no reclassification is made may be affected slightly.

Additional information pertaining to these changes may be obtained by writing to the following address:

HCFA, GROUPER CHANGES, P.O. Box 26681, Baltimore, Maryland 21207

G. Aortic Aneurysm Repair

Over the past several months, we have been investigating the issue of appropriate classification of complex aortic aneurysm repairs. Specifically, we have been attempting to evaluate the classification of aortic aneurysm repairs that involve both the thoracic and abdominal portions of the aorta. Heretofore, there has not been a mechanism within the ICD–9–CM classification system to clearly differentiate these procedures. Consequently, our ability to secure usable data for this evaluation has been significantly hampered.

We have just recently identified a number of cases involving this complex procedure and are beginning to evaluate the data. In addition, new ICD–9–CM codes have been approved that will allow more precise identification of the procedure in the future. We will continue to study the available data throughout the public comment period and may make an additional DRG classification change in the final rule. We specifically invite the public's suggestions and supporting documentation on appropriate classification of thoraco-abdominal aortic aneurysm repairs.

H. Transfer policy (§ 412.4)

Under cost reimbursement, there was no reason to distinguish between discharges and transfers of beneficiaries from one facility to another because all providers involved in the course of a patient's acute-care stay were reimbursed on a cost basis for the medically necessary care provided. However, the prospective payment system is intended to provide full payment, less applicable deductibles and coinsurance, for all inpatient services associated with the treatment of a particular diagnosis in an acute-care hospital. Since the discharge is the basis of payment, it became necessary to distinguish between discharges in which a patient has received complete treatment and discharges in which the patient is transferred to another acute-care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation, we would pay at least twice as much under the prospective payment system for the transfer episode as would have been paid to a single hospital for identical care. We concluded that this would have provided a strong incentive to increase transfers and thereby unnecessarily endanger patients by needlessly increasing their exposure to risks of infection in different hospital settings or by the need to travel to a distant hospital. Therefore, the September 1, 1983 interim final rule contained a policy for payment in transfer situations in § 412.4(d) (then § 405.470(c)(4)). Under this policy, full payment is made to the final discharging hospital in a transfer situation. The transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged. This policy was based upon the assumption that a transferring hospital generally provides only limited services to stabilize a patient before the patient is transferred to a second hospital where the bulk of treatment is provided. The prospective payment rate paid is the rate specific to each hospital on the basis of the DRG under which the patient was treated in each hospital.

In response to the September 1, 1983 interim final rule, several commenters noted that the first few days of any hospitalization were the most resource intensive and that there were situations in which a patient is transferred after considerable resources are expended in the transferring hospital. However, in the absence of clear data to support this claim, we continued the per diem payment approch until we could gather data to evaluate transfers under the prospective payment system and develop an alternative payment under the DRG system. In addition, hospital experience in the first year of the prospective payment system clearly indicated that transferring hospitals occasionally incur costs sufficient to meet cost outlier thresholds. We therefore changed the policy in the August 31, 1984 final rule (§ 412.80(a)(2)) to allow cost outlier payments to qualifying transferring hospitals.

We anticipated that the per diem payment method combined with the required medical review of all transfers would discourage medically unecessary transfers between prospective payment system hospitals while still providing sufficient payment to all hospitals incurring costs for the care of appropriately transferred patients. On several occasions we stated that our goal was to find a way to make one payment for all the hospitals involved in caring for transfer cases.

In response to a comment received on the June 10, 1985 proposed rule, in which we reiterated our intention to go to a single payment system, we stated in the September 3, 1985 final rule (51 FR 35683) that "The single payment methodology will be developed only after we conduct a thorough review of the Part A Tape Bill (PATBILL) file to evaluate the distribution of costs in a transfer situation. The review will enable us to develop a transfer policy that would be designed to result in equitable payments among hospitals and to limit administrative difficulties."

We now have been able to use the 1984 PATBILL file to list the transfers included in the nearly 11 million 1984 bills received through April 28, 1985. About 60 percent of these bills were paid under the Pub. L. 97-248 limitations, and not the prospective payment system. Rather than eliminate pre-prospective payment system discharges from consideration, we decided to assume, for purposes of this analysis, that a transfer occurred in all cases in which the date of discharge from one hospital was the same as the date of admission to another hospital, where both hospitals were or would be subject to the prospective payment system. The contiguous hospital stays were considered as episodes of treatment, involving one or more transfers. We were able to identify over 188,000 of these episodes. The majority of these episodes (174,657 episodes, or 92.90 percent) represented treatment in only two hospitals. These two-hospital, or single-transfer, episodes formed the basic file for our analysis.

After a thorough review of the PATBILL data we have determined that at this time, it is not possible to develop a single payment policy that would be equitable or administratively feasible. These bill data indicate that transfer patterns do not follow our initial assumptions of transfer activity. Transfers represent a relatively small percentage of the total prospective payment episodes (less than 1.8 percent). The average length of stay for the transferring hospitals was fewer than 3 days in only 20 of the 424 DRG categories represented in the listing. These DRGs included only 601 episodes (0.34 percent of total single transfer episodes). The average length of stay in the transferring hospital exceeded the geometric mean length of stay for the DRG assigned to the transferring hospital stay in 328 categories, including 96,698 episodes (55.36 percent).

We are concerned, in light of these average lengths of stay for transfer cases, that transferring hospitals may keep patients longer than necessary in order to receive per diem payments up to the full DRG amount. We recognize, however, that what appeared to be long average lengths of stay in the transferring hospital may merely be the consequence of an artifact of our data base, which includes a substantial number of cases paid under the Pub. L. 97-248 limits. We would expect to find shorter average lengths of stay if our data base included only those cases in which the transferring hospital was already subject to the prospective payment system at the time of the transfer.

Thus, for the present time we have determined that a single payment based only on the DRG of one hospital would probably not be sufficiently high to be split equitably between the two hospitals based on the actual resources that each expended in the episode. Changing to a single DRG payment would result in a reduction in payments to those hospitals that most often transfer patients (frequently rural non-teaching hospitals), and those that most often receive patients (urban teaching hospitals). We do not think that an arbitrary reduction in payment to either group of hospitals would be justifiable merely to achieve a single payment solution.

An alternative to splitting one of the DRG amounts involved between two hospitals would be to develop a transfer DRG based upon a combination of the treatment provided in both hospitals. Presumably, day and cost outlier payments could be based on the combined number of medically

necessary days and allowable charges in the episode. Once again, we do not think that the goal of achieving one payment under the prospective payment system would justify the increased level of administrative complexity that would be involved in assigning a single DRG and payment rate for the combined stays in the transfer episode. The combination of experience in the two hospitals would not appropriately represent the resources involved because the same DRG is assigned in each hospital in only 18.7 percent of the transfer episodes identified in the data base. Of those episodes with different DRG assignments in the sending and the receiving hospital, 42.8 percent of the cases are assigned to DRGs in different major diagnostic categories and 37.1 percent of the cases change from a medical to a surgical DRG. We do not believe that the DRG coding system is set up to assign an appropriate DRG to a given set of diagnoses and procedures unless they have been reviewed and carried out by a single hospital. The treatment provided in each part of a transfer episode results in independent DRG assignments with relative weights representing the diagnoses and procedures identified by the hospital furnishing treatment during that portion of the episode. Similarly, outlier thresholds were based upon the lengths of stays and charges represented in single hospital stays. Unless we were to establish a completely independent computation of the payment amount for a combined DRG, the payment would have to be determined based upon the wage indexes and standardized amounts specific to each hospital. Such hospitals are often located in different urban/rural areas, and even in different census regions. Finally, it is likely that any specific "transfer" DRG would demonstrate a wide variation of charges in the cases assigned to the DRG. We do not believe it would be consistent with our efforts in refining the DRGs to reduce the variation in certain DRGs in order to establish a new DRG that contained a large amount of variation, and that would undoubtedly lead to payment inequities.

Furthermore, the fiscal intermediary would often be responsible for computing such a combined payment weeks after admission to the first hospital. The development of a combined single payment would seem to be a needless complication of the current system with no accompanying gain realized from the elimination of the per diem payment system in favor of one payment.

We do believe, furthermore, that the per diem system acts as a disincentive to inappropriate transfers between acute-care hospitals. The elimination of the per diem payment in transfer situations in favor of full DRG payments to transferring hospitals could result in the proliferation of multiple transfer situations, which now represent a very low percentage of the total transfer episodes reviewed (less than 7.3 percent).

In conclusion, since we are not persuaded at this time that the current transfer policy is inappropriate, and because we are concerned that a single transfer payment policy would not represent an improvement, we are not proposing to modify the current transfer policy as described in § 412.4. We will, however, continue to study and evaluate the transfer policy based on more recent data from prospective payment system hospitals to determine whether modifications may be necessary in the future.

V. Other ProPAC Recommendations

As required by law, we have reviewed the April 1, 1986 report submitted by ProPAC and have given its recommendations careful consideration in conjunction with the formulation of the proposals set forth in this document. The recommendations are discussed throughout this preamble and in the addendum to this proposed rule along with our proposals concerning the same issues. The remainder of the recommendations are discussed below.

A. Adjustments to the Payment Formula

ProPAC believes that the ways in which the prospective payment system formula distributes payments to hospitals are extremely important both to Medicare beneficiaries and to inter-hospital equity. Payments that are adequate on average may be inadequate for certain types of hospitals and the beneficiaries who depend on these hospitals.

1. Disproportionate Share Hospitals (Recommendation) No. 9

Recommendation—ProPAC recommends that an adjustment to the prospective payment rates for hospitals serving a disproportionate share of low-income patients should be implemented as soon as possible. This adjustment should specifically incorporate a definition and methodology in keeping with the character of the adjustments already being considered in Congress. This adjustment should not change the total aggregate dollar amount paid to all hospitals.

Response—Section 9105(a) of Pub. L. 99-272 added a new section 1886(d)(5)(F) to the Act to require that we make an additional payment for hospitals that serve a disproportionate share of low-income patients effective with discharges occurring on or after May 1, 1986. We implemented the payment provisions for disproportionate share hospitals in the May 6, 1986 interim final rule (51 FR 16788).

Section 9105(b) of Pub. L. 99-272 amended section 1886(d)(2)(C) of the Act to require that the standardized amounts be restandardized to reflect the disproportionate share adjustment provided in section 1886(d)(5)(F) of the Act. We are setting forth our proposed methodology for this restandardization in section II./A. of the addendum.

2. Improving the Definition of Hospital Labor-Market Areas (Recommendation No. 10)

Recommendation—The Secretary should improve the definition of hospital labor-market areas for FY 1987, if possible, and no later than FY 1988. For urban areas, the improved definitions should account for a greater amount of the wage variation between inner-city and suburban hospitals. For rural areas, the improved definitions should account for a greater amount of the wage variation between different rural areas within each State and between States. The implementation of improved definitions should not result in any change in aggregate hospital payments.

Response—We addressed a similar recommendation from ProPAC in the September 3, 1985 final rule (50 FR 35663-35664 and 35684-35685). In that final rule, we acknowledged that the current Metropolitan Statistical Areas (MSAs)/non-MSAs may not adequately recognize widely varying hospital labor market conditions, especially among counties classified as rural. We have been looking into possible alternative classification systems that would better define hospital labor markets. However, we believe that further research and study are required before alternative labor market definitions are specified.

Also, as we have noted before, section 1886(d)(2) of the Act defines an urban area as an area within an MSA as designated by OMB or within a similar area, as recognized under the regulations (§ 405.460) establishing limits on total inpatient operating costs under section 1886(a) of the Act. The designation of a county as urban or rural is based on whether or not a particular location qualifies as an MSA or New England County Metropolitan Area (NECMA). MSAs and NECMAs were the

only urban designations recognized under § 405.460 with respect to hospital cost limits. The criteria for MSA or NECMA status are not within our control. EOMB determines which areas qualify as MSAs or NECMAs and the effective date of their qualification is based on standards prepared by the Federal Committee on MSAs, which advises EOMB on metropolitan area definitions. (As discussed elsewhere in this document, the law provides the Secretary with a general exceptions and adjustments authority. We have not in the past used this authority to grant exceptions to the urban/rural criteria because we have no national, objective system of urban/rural designations other than the EOMB MSA designations. However, we are using this authority to grant urban status to a particular rural county effective October 1, 1986. The narrow criteria for this exception should be noted, as well as the fact that this county had previously been urban in the MSA system. We believe that even with this exception we are preserving the urban/rural distinctions based on MSA definitions.)

Section 9103(b) of Pub. L. 99-272 requires that we work with ProPAC to improve the definition of urban hospital labor-market areas. We are required to submit a report to Congress on this matter by May 1, 1987.

3. Rural Hospitals (Recommendation No. 11)

Recommendation—In the original prospective payment legislation of 1983 (Pub. L. 98-21), and the Deficit Reduction Act of 1984 (Pub. L. 98-369), Congress required the Secretary to study and report on a number of rural hospital issues. To date, none of these studies has been submitted to Congress. Preliminary studies by ProPAC suggest that there are potential problems in the way rural hospitals are treated under the prospective payment system. ProPAC urges the Secretary to complete and publish the congressionally mandated studies as soon as possible. If the results of the Secretary's studies indicate that changes in payment policies affecting rural hospitals are warranted, appropriate modifications to current policy, including legislative change, if necessary, should be implemented as soon as possible.

Response—We share ProPAC's concern about the relative vulnerability of rural hospitals under the prospective payment system, and have developed substantial information to describe the short run impact of the prospective payment system on rural hospitals. Our information, which is preliminary, would respond to the congressionally mandated studies in section 603 of Pub. L. 98-21 and section 2311 of Pub. L. 98-369. We will include this information in the 1985 annual report to Congress (due out this year) on the impact of the prospective payment system on classes of hospitals, beneficiaries, other payors for inpatient hospital services, and other providers.

Our preliminary information is based on the 1981 hospital cost data base that was used to implement the prospective payment system. We note, however, that the requisite hospital cost information needed to complete the studies is only now becoming available. Recently, we established two data bases for this purpose. We created a hospital cost report analytic file for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983. We also created a hospital cost report analytic file for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984 (the first year of the prospective payment system). It is our intention that the results of our analyses, which are to be completed by the end of this year, be made available to ProPAC and Congress upon completion.

B. Data Availability and Research

1. Earlier Availability of Medicare Cost Data (Recommendation No. 12)

Recommendation—ProPAC is pleased that the Secretary has taken steps to speed up the availability of Medicare cost report data from the first year of the prospective payment system. ProPAC recommends that making cost data available as soon as possible be an ongoing effort, since these data are vital both to assess the relationship between prospective payments and hospital costs and to analyze the costs of individual DRGs. As part of this ongoing effort, alternative strategies for sampling hospital cost data should be considered. The necessary additional resources should be allocated for timely processing of these data.

Response—We agree with ProPAC's recommendation that Medicare cost report data should be made available as soon as possible for prospective payment system evaluation purposes. We wish to note that it has been a longstanding policy of HCFA to respond promptly to all requests for information and data (including costs reports), subject to the requirements of the Freedom of Information Act (5 U.S.C. 552) and the Privacy Act (5 U.S.C. 552a), and to assist interested parties in conducting research or special analyses. Public access to disclosable information maintained by the Federal government is guaranteed under the Freedom of Information Act.

Ideally, audited cost reports provide an important basis for an assessment of the relationship between prospective payments and hospital costs. However, ProPAC correctly recognized that there is a considerable lag time between the end of a hospital's cost reporting period and the availability of audited cost report information.

We expect the implementation of HCFA's Hospital Cost Report Information System (HCRIS) will do much to speed up the availability of cost report data in various stages of audit for assessing the prospective payment system.

Although HCRIS cost report data were not available in time for ProPAC to use in its deliberations for preparing their April 1, 1986 report, we are willing to provide both audited and unaudited cost report information from this system for ProPAC 's use.

We note that while cost report data may be used to monitor the impact on hospitals of the prospective payment system, one of the goals of the prospective payment system was to break the link between an individual hospital's own costs and its Medicare reimbursement. Furthermore; the cost data are not necessarily of as high quality as in the past because they affect a far smaller proportion of total hospital reimbursement. We question the value of spending our limited administrative resources on full-scale audits considering the anticipated minimal pay-back.

2. Maintaining a Commitment to Data Development and Research on the Prospective Payment System (Recommendation No. 33)

Recommendation—The Secretary should continue to devote substantial resources to data development and research for monitoring and improving the prospective payment system and understanding its effects on the health care system. Studies mandated by Congress already due should be completed and made public as soon as possible, and new studies that analyze more recent data should be designed and implemented as soon as possible. While ProPAC and other organizations will participate in this process, the major commitment to prospective payment system data development and research must reside with DHHS.

Response—We agree with ProPAC that data development and continuing research are vital to the maintenance of an equitable prospective payment system. As available resources permit,

we will devote our efforts to refining the prospective payment system through the identification and resolution of problems, and improving data bases for analysis.

C. Beneficiary Concerns

Quality of care under the prospective payment system has been a paramount concern of ProPAC since its inception. ProPAC believes that there are a number of ways in which the quality of care can be maintained or improved under the prospective payment system.

1. Beneficiary and Provider Information (Recommendation No. 15)

Recommendation—The Secretary should take immediate action to provide more and better written information about the Medicare prospective payment system to beneficiaries and providers of care. The Department should work with providers, beneficiaries, and associations of these groups to produce and disseminate this information. Associations of providers and beneficiaries should also increase their own efforts to educate and inform their members better about the Medicare prospective payment system.

Response—We agree with ProPAC that Medicare beneficiaries should be provided with clear and precise information about the prospective payment system. To that effect, we are preparing a new pamphlet on the prospective payment system due for release by late spring. The pamphlet, responding to comments from ProPAC and other interested parties, will provide Medicare beneficiaries a better understanding of the prospective payment system. Copies of the pamphlet will be made available to Medicare beneficiaries not only through the local Social Security district offices, but also through other distribution channels, such as the Administration on Aging Network and other beneficiary representative organizations.

2. Notice to Beneficiaries of Rights (Recommendation No. 16)

Recommendation—Beneficiaries should be made aware of the process of reconsideration and appeal of a denial of coverage for continued inpatient hospital care. Notification should be through a written notice or information bulletin. It should explain beneficiary rights in a clear, helpful, and understandable manner. In addition to a clear statement of rights, the bulletin should inform beneficiaries that they should not accept any oral communication to the effect that they must leave the hospital because their "coverage" has "run out" or because there is a limit on the number of days "allowed" by Medicare for a DRG. The bulletin should be distributed at the time of admission or as soon thereafter as is appropriate based on the patient's clinical condition. However, additional avenues of distribution should also be developed.

Response—On February 24, 1986 we released a notice for Medicare beneficiaries to be distributed to them upon admission to a hospital. The notice explains to beneficiaries their rights under the prospective payment system and informs them of how to appeal a decision if they believe they are being discharged prematurely. In addition, we are developing a new pamphlet to discuss in greater detail Medicare beneficiary appeal rights. The new pamphlet will combine the current physician appeals and hospital appeals pamphlets, and add new information for beneficiaries on appeal rights under the prospective payment system. We intend to release this pamphlet within the next few months.

We understand that the geometric mean lengths of stay used in determining the outlier thresholds may have been misperceived as "maximum" lengths of stay, thereby fostering the misunderstanding, among hospitals, doctors, and the public generally, that Medicare does not cover inpatient services for days beyond the average lengths of stay. In the September 3, 1985 final rule (50 FR 35710), we reiterated our policy that there are *no* requirements under the prospective payment system that Medicare patients classified within a given DRG be discharged after a specific number of days as indicated by the geometric mean length of stay for that DRG, *nor* will hospitals be paid for only a certain number of days of care for each discharge within a given DRG. To assist the reader in understanding the difference between the arithmetic and geometric mean lengths of stay, we published the arithmetic mean lengths of stay in Table 5 of the September 3, 1985 final rule (50 FR 35722).

To further dispel any misunderstanding about lengths of stay by DRG, we are publishing in this document, in Table 7 of the Addendum, the range of lengths of stay for each DRG in terms of selected percentiles. Each percentile threshold represents the proportion of Medicare discharges in each DRG with lengths of stay less than or equal to the indicated value.

These data provide the reader an idea of the variability in Medicare length of stay for each of the DRGs. For example, from the presentation in Table 7 of the addendum, one can see that in FY 1984, 90 percent of the patients in DRG 127 (heart failure and shock) experienced hospital stays of less than 17 days (that is, the 90th percentile length of stay value is 17), even though the mean length of stay for this DRG was only 8.8 days. However, ten percent of the patients were in the hospital less than 3 days (that is, the 10th percentile length of stay value is 3).

3. PRO Episode of Care Review (Recommendation No. 17)

Recommendation—ProPAC recommends that the focus of PRO quality of care review should be, to the extent possible, on the entire episode of care. The PRO's review should include, in addition to the period of hospitalization, the quality of care (and outcome) related to the overall episode of illness, including, if appropriate, skilled nursing or home health care.

Response—During the 1986–1988 contract period, PROs will substantially intensify the quality of care aspects of inpatient hospital medical review, including discharge planning. We recognize the importance of PRO review of a patient's condition at the time of discharge. Therefore, every case under PRO review will be subject to—

- Discharge review criteria to detect premature discharges; and
- Review of discharge planning, to determine that the availability of needed post-discharge care was considered.

In addition, six PROs are currently involved in a pilot study to determine a patient's health status at the time of hospital discharge. We believe that the results from this study will provide insight into the extent of premature discharges from hospitals under the prospective payment system. In addition, we intend to identify the most effective method of review for dealing with this problem. It should also be noted that HCFA is exploring the possibility of developing a survey-type study on post-hospital care received by Medicare beneficiaries. This study will focus on both covered and non-covered services in an attempt to assess the post-hospital needs of beneficiaries and how the Medicare program addresses those needs.

4. PRO Review of Outpatient Surgery (Recommendation No. 18)

Recommendation—ProPAC is concerned that efforts to shift surgical services from the inpatient to the outpatient setting could have an adverse impact on quality of care for certain Medicare beneficiaries. The PROs should be required to review and monitor the quality of care (and

outcome) of outpatient surgery for selected patients and procedures. As a starting point, the PROs should be required to review outpatient surgery cases for those procedures that have been identified for preadmission review, including in particular a sample of those cases for which the PRO has denied admission on preadmission review.

Response—Section 9401 of Pub. L. 99–272 requires 100 percent PRO review for certain surgical procedures including mandatory second opinion for those cases. We are in the process of developing a list of surgical procedures for which PRO review would be required. We are also considering changes in medical review for outpatient surgery for certain procedures.

Also, under section 9307 of Pub. L. 99–272, PRO review is required on a preprocedural basis for assistants at surgery for certain cataract operations whether the services are performed on an inpatient or outpatient basis. The Secretary, after consultation with the Physician Payment Review Commission, is responsible for developing recommendations and guidelines with respect to other surgical procedures for which an assistant at surgery is generally not medically necessary, and the circumstances under which the use of an assistant at surgery is generally appropriate but should be subject to prior approval of an appropriate entity.

We believe that this level of activity is sufficient to deal with potential quality problems in the outpatient setting. If further experience reveals additional problems or issues, we would, of course, re-examine this position.

5. *Recalculating the Inpatient Hospital Deductible (Recommendation No. 19)*

Recommendation—The Secretary should seek a legislative change in the formula for computing the inpatient hospital deductible so that the annual increase in the deductible is more consistent with the annual per-case increase in Medicare payments to hospitals. The proportion of the costs of inpatient hospital care borne by Medicare beneficiaries has inappropriately increased as a result of significant declines in length of stay experienced since the inception of the prospective payment system. This proportion should be lowered to its calendar year 1983 level.

Savings from shorter lengths of stay have benefited both hospitals and the Federal government, and ProPAC believes that Medicare beneficiaries should share in these gains as well. Hospitals have gained from the decline in length of stay because they keep the difference between the prospective payment and their costs for treating Medicare beneficiaries. The Federal government has gained as well, since the decline in the length of stay has been one of the factors considered in limiting increases in prospective payment rates.

Response—Section 1813(b)(2) of the Act specifies the manner in which the hospital inpatient deductible is computed. (The deductible represents the amount of beneficiary cost-sharing before the Medicare program assumes any liability for the additional costs of covered inpatient services.) The Secretary is required to determine the deductible amount each year according to the formula contained in the law.

For calendar year 1985, the amount of the deductible was $400. For calendar year 1986, the deductible increased 23 percent to $492. (For detailed explanations of how these figures were determined, see the notices of September 28, 1984 (49 FR 38510) and September 30, 1985 (50 FR 39940) or the 1985 (March 28, 1985) and 1986 (April 1, 1986) Annual Reports of the Board of Trustees of the Medicare Part A Trust Fund to Congress). The dramatic increase in the inpatient deductible was largely caused by the significant decrease in inpatient hospital utilization evident since the inception of the prospective payment system. As hospitals have responded to the financial incentives of the system, Medicare length of stay and admission rates have decreased substantially. Because payments for inpatient services are now being spread over fewer days, the per-diem formula for calculating the inpatient deductible described in section 1813(b)(2) of the Act has resulted in a substantial increase in the amount of the inpatient deductible, an increase that far exceeds the amount of inflation in the cost of furnishing hospital care.

To avoid future increases of this magnitude, ProPAC has recommended that the deductible reflects a per discharge rather than per-diem payment formula, an approach consistent with the prospective payment system. The basis for ProPAC's recommendation is an anticipation of further significant declines in the days of care per admission furnished to Medicare inpatients.

We are currently examining this issue and possible alternatives for calculating the inpatient hospital deductible. Under section 9128 of Pub. L. 99–272, the Senate Finance Committee is expected to report legislation to reform the calculation of the annual increase in the deductible so that it is more consistent with annual increases in Medicare payments to hospitals.

D. Patient Classification and Case Mix

1. Improving the Measurement of Hospital Case Mix (Recommendation No. 20)

Recommendation—ProPAC believes that the DRG system is currently the most appropriate of the available measures of hospital case mix for the Medicare prospective payment system and should be retained in principle as the system upon which to base Medicare payments to hospitals. Resource use varies considerably, however, within some DRGs. Therefore, ProPAC intends to continue its analysis of individual DRGs and to undertake a systematic evaluation of the entire system. The goal is to identify potential problems in DRG construction and classification and recommend changes that will improve the homogeneity within DRGs and the equity of payment across hospitals.

Response—We agree with ProPAC's assessment of the DRG system and support its evaluation efforts. We anticipate the evaluation of the DRG system to be an ongoing process. To improve DRG assignment criteria and refine the grouping methodology in order to obtain more clinically homogeneous categories reflective of actual inpatient resource consumption, we modified the DRG classifications in the September 3, 1985 final rule (50 FR 35647) and made further modifications in the final notice located elsewhere in this edition of the **Federal Register**, as discussed above.

2. Process for Maintaining and Updating the ICD–9–CM (Recommendation No. 21)

Recommendation—ProPAC recommends that the Secretary should establish a mechanism for maintaining and updating ICD–9–CM diagnosis and procedure codes in a timely and effective manner. This process should include adequate educational support for all users.

Response—The ICD–9–CM Coordination and Maintenance Committee has already been established for the purpose of maintaining and updating the ICD–9–CM codes. The Committee is comprised entirely of representatives of Federal agencies with an interest in ICD–9–CM coding and its modificiation, updating, and use for Federal programs. The Committee is co-chaired by staff from HCFA and the National Center for Health Statistics.

Public meetings of the Committee are held quarterly. Meeting dates and locations are announced in the **Federal Register**. The public is encouraged to submit items for the agenda, attend the

public meetings and actively participate in the decisions. Although only the members of the committee may vote on the issues presented, their decisions are not made without consideration of the opinions expressed by non-Federal users of ICD–9–CM codes. Past meetings of the committee have been attended by representatives of the AHA, ProPAC, American Medical Records Association and the Commission on Professional and Hospital Activities, as well as noted physicians and hospital medical records administrators.

As was previously stated in the March 13, 1986 proposed notice (51 FR 8776) concerning DRG classification changes, new ICD–9–CM codes adopted by July 1 of each year by this Committee, would accommodated by the GROUPER program, without DRG classification changes, at the beginning of the next Federal fiscal year. The ICD–9–CM Coordination and Maintenance Committee has thus far approved new procedure codes in 9 areas. The Committee held its spring meeting on May 21 and 22, 1986. New ICD–9–CM codes are currently being considered to identify the following:

Parenteral and Enteral Nutrition
HTLV–3/LAV Infections
Pacemaker Technology
Gastric Endoscopic Balloon Procedures
Percutaneous Balloon Valvoplasty
Lasers
Ureterscopy and Pyeloscopy
Percutaneous Angioscopy
Endoscopic and Percutaneous
Procedures on the Biliary Tract
Percutaneous Embolization
Rectosigmoid Resection

We also note that the Committee mission includes establishment of educational activities related to the appropriate use of ICD–9–CM coding. An educational subcommittee was formed to review available ICD–9–CM educational material. Suggestions for action items for the subcommittee have been requested from attendees at the public meetings.

As part of its educational activities, the Committee spends a considerable portion of its time on revision of instructions included in the coding manuals. Addendum, errata and revisions of the "includes notes, excludes notes and alphabetical indexes" are considered. The Committee intends that publication of all new codes and coding actions be accompanied by appropriate indexing changes and instructions.

Finally, we wish to point out that current plans do not envision the revision of volume 3 of ICD–9–CM to accompany publication of ICD–10. (ICD–10 will only include diagnosis codes.) We are presently exploring, with interested parties, how to best handle long-term coding issues. Intuitively, we believe for Medicare purposes that a single coding system for all procedures, regardless of whether performed in hospitals or physician offices, would be more appropriate than the present method of using two unique procedure coding systems for each aspect of the program. We welcome comments and suggestions on this issue as we continue to evaluate our long-term coding policies.

3. Process for Interpretation and Assignment of Existing Codes (Recommendation No. 22)

Recommendation—The Secretary should ensure that interpretation and assignment of existing ICD–9–CM diagnosis and procedure codes for payment purposes strictly adhere to coding rules and guidelines. In order to maintain the integrity and uniformity of the coding system while allowing flexibility for payment purposes, the process for interpretation and assignment of existing ICD–9–CM codes should be assigned to one authorized group.

Response—As ProPAC notes in its discussion of this recommendation, there are a number of organizations currently disseminating conflicting coding advice. We consider the ICD–9–CM Coordination and Maintenance Committee as the single group officially authorized to interpret and clarify coding guidelines and assign new codes to the ICD–9–CM system. We believe the educational role and responsibilities of this Committee encompass appropriate interpretation and assignment of existing ICD–9–CM codes. By having a single entity dually responsible for interpretation and assignment of existing codes as well as revision and updating of the coding manuals, we believe we can assure consistent and expeditious dissemination of coding advice. Of course, as ProPAC pointed out in its discussion of this recommendation, the Department reviews and approves material published in the AHA's *Coding Clinic*. Thus users of the AHA's service may assume that the *written* material is consistent with our position on coding.

Like ProPAC, we recognize the necessity of curtailing the dissemination of inaccurate and conflicting coding advice. Under contract to HCFA, the PROs are responsible for verifying the accuracy of ICD–9–CM codes reported on Medicare bills. The PROs continue to review a sample of claims, correct coding errors, and make educational contacts with appropriate hospital staff when problems are identified. We have established a procedure whereby PROs can direct coding questions to HCFA staff members intimately involved with the ICD–9–CM Coordination and Maintenance Committee. In addition, we now require PROs to have a trained coding person on staff and we intend to increase coding instructional material disseminated to the PROs from HCFA. We believe we are taking the action necessary to encourage consistent application of ICD–9–CM; however, there is little we can do to abate the dissemination of inaccurate or inconsistent instructions from private sources.

4. Interim Mechanism for Coding Problems (Recommendation No. 23)

Recommendation—The Secretary should establish an interim mechanism to allow early identification of new technologies, procedures and diagnoses and more appropriate DRG assignment when ICD–9–CM codes cannot be updated in a timely manner.

Response—We support ProPAC's recommendation for a refinement to the ICD–9–CM codes to permit more rapid identification of new technologies and are currently considering alternatives for implementing such a mechanism. We are particularly soliciting comments and suggestions on how best to adopt the Medicare claims processing system to assure more rapid availability of data on new and changing technologies.

E. DRG Classifications and Weighting Factors

1. Adjustment of the Labor Portion of the Standardized Amounts for Some DRGs Involving Expensive Devices (Recommendation No. 24)

Recommendation—The labor portion and nonlabor portion of the standardized amounts should be redefined for DRGs 39 (lens procedures with or without vitrectomy), 104 and 105 (cardiac valve procedures with pump, with and without cardiac catherization, respectively), 209 (major joint and limb reattachment procedures), 471 (bilateral or multiple major joint procedures of the lower extremity), and the newly defined DRGs for pacemaker implantation and replacement (Recommendations 25 and 26), implantable defibrillators (Recommendation 27), and penile prostheses (Recommendation 28). The new portions should more closely reflect the labor-related and nonlabor-related shares of costs for cases in each of these DRGs. These recalculations should be made so that total hospital payments

remain unchanged. The correct labor and nonlabor portions of the standardized amounts should be calculated from data currently being generated in HCFA's study of the labor portion of costs by DRG. If this information proves to be incomplete, the portions should be calculated from available cost and charge data for these DRGs. The Secretary should study the need for adjustments to the labor and nonlabor portions of the standardized amounts in all DRGs.

Response—We are continuing our studies to identify DRGs with high nonlabor-related cost shares. Our analyses of FY 1984 PATBILL charge patterns confirm ProPAC's finding that the following DRGs have charges for supplies that average approximately 20 percent or more of total inpatient charges:

- DRG 39 (lens procedures).
- DRG 115 through 118 (cardiac pacemakers).
- DRG 209 (joint and limb procedures).
- DRG 341 (penis procedures).

However, the ratio of average charges for supplies to total inpatient charges for DRGs 104 and 105 (cardiac valve procedures), which represent the highest average charges of the nine DRGs under study, are lower than 20 percent.

Our review confirms ProPAC's conclusion that rural and urban hospital charges for cases in the selected DRGs are more similar than those for other DRGs because both types of hospitals must buy devices from the same national markets. But the fact that some DRGs have supply charges that account for a much higher share of a bill than the average supply charge of 8.0 percent does not justify an automatic adjustment to the labor and nonlabor portions of the standardized amounts.

We believe that increasing the nonlabor share for these DRGs would minimally redistribute funds from urban to rural hospitals. Our reimbursement simulations, which assume no changes in the classes of hospitals performing the identified DRGs, indicate that for each ten percent reduction in the labor-related portion of the standardized amounts for *all* DRGs, rural hospitals would gain up to four-tenths of one percent, while urban hospitals would lost about one-tenth of one percent. Thus, lowering the labor-related portion for only the identified DRGs would result in a much smaller effect. In 1984, these DRGs represent nearly seven percent of urban hospital cases and over eight percent of urban hospital revenues, but only less than four percent of rural hospital cases and about six percent of rural hospital revenues.

Moreover, lowering the labor-related portion of the standardized amounts for some DRGs logically implies increasing that portion for other DRGs. This could imply that ultimately the standardized amounts would be differentiated for each DRG. We believe to do so would unduly complicate the administration of the prospective payment system and may distort hospital incentives. While the ProPAC analysis and our preliminary analyses suggest that rural hospitals are relatively disadvantaged on certain types of cases, namely, those in which the nonlabor portion is higher than the national average, they are, by the same token, advantaged on those types of cases in which the nonlabor-related share is less than the national average. Accordingly, we believe that it is preferable to use national averages for all cases since there is no evidence to suggest that a class of hospitals is systematically disadvantaged in their entire Medicare business by our use of national average labor-related and nonlabor-related shares. Therefore, we are not accepting ProPAC's recommendation to adjust the labor and nonlabor portions of the standardized amounts for certain DRGs.

2. Reclassification of Pacemaker Cases Based on Type of Device (Recommendation No. 25)

Recommendation—Prior to recalibration, the DRGs involving implantation of cardiac pacemakers (currently DRGs 115 through 118) should each be restructured into two DRGs, one for cases involving dual-chamber or functionally similar pacemakers, and one for cases receiving other single-chamber pacemakers. New ICD–9–CM procedure codes should be created to distinguish between these types of cases. A mechanism should be established to evaluate the appropriateness of all implants involving dual-chamber of functionally similar pacemakers. In the initial year of this new classification, the weights for all pacemaker DRGs should be calculated using charge data from the Part A tape bills (PATBILL) file and data on cost differences between pacemaker types.

Response—We do not agree with this recommendation for several reasons. First, DRGs 115 through 118 cover a wide spectrum of pacemaker procedures ranging from the initial implantation of a pacemaker system where there is acute myocardial infarction, heart failure or shock, through the replacement of an electrode. We do not believe that restructuring all of these DRGs into two classifications based on the type of pacemaker implanted would be appropriate in view of the numerous pacemaker procedures included in each DRG. Such cases involving implantation of a pacemaker (the initial implantation or replacement) should be grouped into either DRG 115 or 116. These are the only DRGs that should reflect any differences due to the distinction in the cost of the two devices. If we propose changes on this basis in pacemaker case at a future date, our changes would be limited to DRGs 115 and 116. At this time, however, there is no method available on our records for distinguishing between the two types of devices, and therefore, we do not have a method of establishing different DRGs for single and dual-chamber pacemakers.

As the guidelines indicate, if the use of the dual chamber is not appropriate, we do not cover it. With respect to ProPAC's concerns on the appropriate use of dual-chamber pacemakers, we note that we issued revised guidelines, effective on May 9, 1985, which clarify our coverage policies on dual-chamber pacemakers (Section 65–6 of the Coverage Issues Manual (HCFA-Pub. 6), formerly the Coverage Issues Appendix of the Part A Intermediary Manual). We believe these policies respond to ProPAC's concerns in this matter.

In the interim, we agree that a change in ICD–9–CM coding would be the first step in any evaluation. This would allow for the collection of data for evaluation purposes, and to propose changes, as appropriate. As noted above, new ICD–9–CM codes to distinguish single-chamber from dual-chamber pacemakers have been proposed.

3. Reclassification of Pacemaker Replacement Cases (Recommendation No. 26)

Recommendation—Prior to recalibration, the cases involving replacement of a permanent cardiac pacemaker, except those with myocardial infarction, congestive heart failure or shock, should be reassigned to DRGs that include only pacemaker replacements.

Response—We do not agree with ProPAC's recommendation because we believe the inconsistencies of assigning a DRG weight for the cases involving pacemaker replacement, as identified by ProPAC, are a result of inappropriate use of the ICD–9–CM codes rather than the DRG classification system. The ICD–9–CM coding system, if properly used, provides for the grouping of cases that involve replacement or removal of electrodes (and other changes to the

system) to DRG 117. Likewise, because replacement of a pulse generator is more resource intensive than the replacement or removal of electrodes, it would properly be assigned to DRG 118.

The replacement of a permanent pacemaker in its entirety is even more resource intensive than the pacemaker procedures in DRGs 117 and 118. If properly coded, that is, using operating room procedure codes 3770 (Insertion of cardiac pacemaker, not otherwise specified), 3773 (Insertion of permanent pacemaker into atrium, transvenous route), 3774 (Insertion of permanent pacemaker into ventricle, transvenous route), 3775 (insertion of permanent cardiac pacemaker into unspecified site, transvenous route), 3776 (Insertion of permanent pacemaker into epicardium), and 3777 (Insertion of permanent cardiac pacemaker, unspecified approach), the replacement of a permanent pacemaker would be assigned to either DRG 115 or 116 depending upon the presence or absence of acute myocardial infarction, heart failure, or shock.

We believe that careful and consistent use of the surgical codes for pacemaker-related procedures would alleviate the difficulties identified by ProPAC. We are not, therefore, reassigning cases involving replacement of a permanent cardiac pacemaker.

4. Implantable Defibrillator (Recommendation No. 27)

Recommendation—Implantable defibrillator cases should be assigned to a unique DRG. The labor portion and nonlabor portion of the standardized amounts should be redefined for this new DRG to reflect the labor-related and nonlabor-related shares of costs for these cases.

Response—We believe there are not sufficient data available currently to accept or reject this recommendation. At the time coverage was extended to the Automatic Implantable Cardioverter Defibrillators, we recognized that a separate DRG was a consideration but that additional cost and charge data were needed before this decision could be made. We believe that the best approach when insufficient data are available is the one we have taken in the final notice of DRG classification changes located elsewhere in this edition of the **Federal Register**, which was to—

- Establish a unique ICD–9–CM code as soon as possible;
- Make payment based on an existing DRG; and
- Collect data.

When cost and charge data are available, a decision can be made as to the appropriate placement of the new procedure within the system.

5. Penile Prostheses (Recommendation No. 28)

Recommendation—Prior to recalibration, ProPAC recommends that cases involving the implantation of a penile prosthesis should be removed from DRG 341 and reassigned to a unique DRG. The labor portion and nonlabor portion of the standardized amounts should be redefined for this new DRG to reflect the labor-related and nonlabor-related shares of costs for these cases. ProPAC contends that the difference in charges for DRG 341 (between penile prosthesis cases and other cases within this DRG), estimated from the 1984 PATBILL data at about 35 percent, is due largely to the cost of the prosthesis.

Response—In analyzing the FY 1984 PATBILL data for DRG 341, we find little reason to believe that reclassification of cases involving penile prosthesis procedures is appropriate at this time. Our analysis indicates that—

- DRG 341 shows very little variation in charges in comparison to the other DRGs. (The coefficient of variation equals .55.);
- Forty-three percent of the penile prosthesis cases showed standardized charges at or below the average standardized charge for the DRG;
- The most frequently reported standardized charge range (mode) for these cases was approximately 28 percent lower than the average standardized charge for DRG 341;
- The median standardized charge and the mean standardized charge for penile prosthesis cases were only slightly higher (nine percent and 17 percent respectively) than the average standardized charge for DRG 341; and
- Distributional analysis indicates that the same hospitals performing penile prosthesis procedures are also performing lower cost penis procedures. Nationally, only one hospital furnished more than 30 penile prostheses to Medicare beneficiaries during FY 1984. Thus, it seems that hospitals do not have more difficulty with DRG 341 than any other DRG.

We note that there are some differences between ProPAC's analysis and our own. This is primarily due to the fact that ProPAC used unadjusted charges while we analyzed standardized charges. We believe it is more appropriate to evaluate standardized charges as such charges eliminate much of the individual variation in hospital charge structures attributable to wages and teaching status. Moreover, standardized charges serve as the basis for the DRG weighting factors. We note that ProPAC used standardized charges in much of its analysis related to other DRG classification changes. In reviewing ProPAC's analysis, we also noted that removal of penile prosthesis procedures from DRG 341 results in an increased coefficient of variation for the remaining penis procedures. Despite ProPAC's conclusion that removal of penile prosthesis is appropriate, the data indicate that penis procedures are more homogeneous in resource intensity when grouped with penile prosthesis than when prosthesis procedures are removed. That is, although penile prosthesis cases may be more resource intensive than many minor penis procedures, they are similar in resource or less resource-intensive than several other penis procedures cases, such as reconstruction of penis. Thus, ProPAC's own data demonstrate that the homogeneity of DRG 341 is superior without reclassification.

In addition, we do not believe it is appropriate to establish single procedure DRGs under most circumstances. The basic concept of the DRG system is to group a number of clinically similar diagnoses and procedures that are similar in resource use. The establishment of single-procedure DRGs runs counter to the grouping concept and would establish a precedent to classify and develop weighting factors separately for all individual procedures and diagnoses. Under such a precedent, the number of DRGs could grow dramatically, rapidly resulting in an unmanageable system. In addition, establishing DRGs along these lines would represent a major step away from the prospective payment system as currently established, and a major step back toward a cost-based reimbursement system, in which payment to a hospital is closely tied to the actual costs incurred in furnishing individual services.

We believe that procedure-specific DRGs should be utilized only in those situations in which the data indicate that the procedure is neither clinically coherent nor homogeneous with respect to resource use with any other procedures in the major diagnostic category. As we indicated above, our analysis of the data on penile prostheses does not indicate that this is the situation.

6. Additional Payment for Magnetic Resonance Imaging (Recommendation No. 29)

Recommendation—ProPAC recommends that, for a period of three years, Medicare should pay hospitals an

additional amount for each covered inpatient magnetic resonance imaging (MRI) scan performed on a Medicare beneficiary in a prospective payment system hospital. Under existing capital payment policy (that is, payment of capital on a reasonable cost basis), the add-on for FY 1987 should be $124 for each scan performed on beneficiaries in institutions in which Medicare pays for the capital costs of an MRI scanner and $282 for each scan performed on a beneficiary in a hospital other than the hospital in which the beneficiary is currently an inpatient. In FY 1988 and FY 1989 the add-on amounts for all hospitals should be recalculated to reflect any change in the average cost of an efficiently produced scan and changes in capital payment policy.

Response—Because of the costliness of MRI, ProPAC has recommended an explicit add-on to the prospective payment rate for Medicare discharges in which the procedure was performed. MRI was not reflected in the 1981 cost data base used to develop the initial prospective payment rates. Therefore, ProPAC maintains that, absent historical data, an additional payment for MRI would provide an incentive for the adoption of a clinically beneficial although costly technology.

MRI is a relatively new medical technology involving the production of images when a patient is placed in a controlled magnetic field. While similar to computerized tomography (CT) scanning, MRI can provide images along more than one plane, without use of radiation and, often does not require the use of contrast agents for image enhancement. Many clinicians maintain that MRI provides images of greater clarity compared to other alternative technologies, particularly in sites surrounded by bone.

While this technology is covered by the Medicare program, MRI typically involves large capital outlays. The potential impact of MRI is substantial because of the large number of DRGs that may reflect this procedure.

We believe that providing an explicit additional payment for the use of a particular technology would establish a precedent that runs counter to one of the principal objectives of the prospective payment system; that is, the establishment of a single payment rate for all cases classified within a DRG regardless of the specific resources used in any particular case. Moreover, to the extent MRI replaces other imaging technologies that are reflected under the prospective payment rates, we believe that an additional payment would be unwarranted. In fact, a separate payment could be counterproductive because it potentially creates an incentive to use the technology in cases in which it may not be appropriate. Furthermore, such a payment would insulate hospitals from the consequences of their choices with respect to resource use. While there would be no "cost" to hospitals that use MRI in addition to other techniques, we would be providing a real bonus to hospitals that use MRI instead of other imaging techniques. In addition, we point out that a portion of capital payments would continue to be based on actual costs during the capital payment transition period. Therefore, the Medicare program already reimburses hospitals for its share of the capital costs of new technology.

In addition, we note that under section 1886(e)(2) of the Act, ProPAC is required to consider changes in technological (such as the MRI technology) and scientific advances in determining its recommended percentage change in the prospective payment rates. Since the Secretary is required under section 1886(e)(4) of the Act to take account of ProPAC's recommendations, we also consider technological changes and scientific advancements in determining the applicable percentage change in the prospective payment rates. We believe the allowance that we are proposing for science and technology in this document, and that we will consider each year, represents the appropriate means of taking into account such special technologies. Rather than proposing a special add-on for MRI technology, which would only benefit those hospitals that make use of that technology, the general allowance for technological and scientific advances permits hospitals to choose which technological advances are appropriate for the care and services they furnish to Medicare beneficiaries.

If the widespread adoption of MRI technology materially affects the relative resource use of specific DRGs, the DRG relative weights would automatically reflect the resources associated with MRI as cases involving MRI are used to recalibrate the DRGs. Therefore, because the prospective payment system already provides sufficient means to incorporate both the capital and operating costs of new technology, we have not adopted ProPAC's recommendation.

7. Extracorporeal Shock Wave Lithotripsy (Recommendation No. 30)

Recommendation—Prior to recalibration, cases in which extracorporeal shock wave lithotripsy (ESWL) is the principal procedure should temporarily be removed from DRG 324 and reassigned to DRG 323. The payments and costs for all cases in this DRG should be monitored to determine the appropriateness of prospective payments for operating costs. A unique procedure code should be identified for this procedure.

Response—ProPAC's analysis found that payment under DRG 324 substantially understated the cost of ESWL. We have received similar correspondence on this matter ever since Medicare coverage was extended to this new technology. Heretofore, we had no means of identifying this procedure in our data base. Consequently, our past analyses have been based on limited data derived largely from institutions involved in clinical testing of ESWL and our ability to resolve the problem has been severely limited.

As stated in the final notice of changes to the DRG classification system, published elsewhere in this issue of **Federal Register**, a unique procedure code has been approved for ESWL (59.96). Given that we will now be able to identify this procedure, we are accepting ProPAC's recommendation. That is, we are proposing to classify all cases involving a principal diagnosis of urinary stones treated by ESWL to DRG 323, regardless of age or absence of complications or comorbidities. We will continue to monitor the resource intensity of ESWL and will consider further classification changes if necessary.

8. Lymphomas and Leukemias (Recommendation No. 31)

Recommendation—Prior to recalibration, cases currently assigned to DRGs involving lymphoma, leukemia, and other related diagnoses (DRGs 400–404) should be reclassified into one of five newly defined DRGs:

DRG 400—Lymphoma/leukemia with major operating room procedure;

DRG 401—Acute leukemia without major operating room procedure;

DRG 402—Lymphoma/non-acute leukemia with other operating room procedure and complication/comorbidity;

DRG 403—Lymphoma/non-acute leukemia with other operating room procedure or complication/comorbidity; and

DRG 404—Lymphoma/non-acute leukemia without operating room procedure or complication/comorbidity.

ProPAC recommends that the new classification provide a unique DRG for

acute leukemia cases not involving a major operative procedure (as distinct from non-acute leukemia and lymphomas), eliminate age as a criterion for DRG assignment, and modify present classification based on operative procedure, complications and comorbidity. Other ways of further improving these DRGs should continue to be explored.

Response—We agree with ProPAC that DRGs 401 through 404 are more heterogeneous than most DRGs and, consequently, may indicate that reclassification of cases within these DRGs is appropriate. We are particularly concerned, however, with ProPAC's proposed reconfiguration of DRG 403, which combines about 7,000 surgical cases of lymphoma and non-acute leukemia with some 28,000 non-surgicial cases of lymphoma and non-acute leukemia with complications or comorbidities. Our analyses indicate that the latter group of cases are about 25 percent more resource intensive than the surgical cases without complications or comorbidities. Moreover, the basic logic of the GROUPER program is structured so as to establish DRGs that are either medical or surgical. Each medical DRG is assigned based on a specific set of principal diagnoses, whereas a surgical DRG generally does not entail looking at a diagnosis but only at procedures. The predominant exception to this logic occurs in cases where a principal diagnosis alone explains resource use, without regard to whether or not a surgical procedure is performed. This generally occurs when cases with a specific principal diagnosis virtually always entail surgical treatment or virtually never entail surgical treatment. We have found the latter to be the case with acute leukemias in that fewer than four percent of the cases in our data base involved surgical treatment.

In light of our analysis and the foregoing discussion, we believe similar improvements in the homogeneity of these DRGs may be achieved without disrupting the logic inherent in the current classification structure. Therefore, we are proposing to accept the basic premises of ProPAC's recommendation. That is, we are accepting ProPAC's suggestion that acute leukemia cases without major operating room procedure be classified into a single DRG. We have added acute leukemia not otherwise specified (code 2080) to the other acute leukemia codes included in ProPAC's recommendation. In addition, we are accepting ProPAC's suggestion that age consideration be eliminated from the decision tables for classification of lymphoma/leukemia cases.

We are proposing to establish the following classifications for lymphoma/leukemia patients:

DRG 401—Lymphoma/non-acute leukemia with other operating room procedure with complications and/or comorbidities.

DRG 402—Lymphoma/non-acute leukemia with other operating room procedure without complications and/or comorbidiies.

DRG 403—Lymphoma/non-acute leukemia without operating room procedure with complications and/or comorbidities.

DRG 404—Lymphoma/non-acute leukemia without operating room procedure without complications and/or comorbidities.

DRG 405—Acute leukemia without major operating room procedure, age less than 18.

DRG 473—Acute leukemia without major operating room procedure, age greater than 17.

Acute leukemia is defined as patients with a principal diagnosis of—

- Acute lymphoid leukemia (code 2040);
- Acute myeloid leukemia (code 2050);
- Acute monocytic leukemia (code 2060);
- Acute erythremia (code 2070); and
- Acute leukemia, not otherwise specified (code 2080).

Although the reclassification we are proposing is somewhat different from that proposed by ProPAC, we have found similar improvements in homogeneity. We believe it is appropriate to create an additional DRG for acute leukemia cases without major operating room procedure and to maintain the distinction between surgical and medical lymphoma and non-acute leukemia cases.

9. Upper Extremity Procedures (Recommendation No. 32)

Recommendation—Prior to recalibration, cases involving procedures of the upper extremity that are currently classified in DRGs 223, 224, 228, and 229 should be reassigned based on anatomical location and the presence of systemic collagen vascular disease or implantation of joint prostheses or complications and/or comorbidities. Nonsurgical hip fracture cases currently being assigned to DRGs 223, 224, 225, 228, and 229 should be reassigned to the appropriate medical DRG.

Response—ProPAC's analysis in this regard includes 2 pairs of DRGs. DRGs 223 and 224 include upper extremity procedures except humerus and hand; DRGs 228 and 229 include humerus and hand procedures. With regard to DRGs 223 and 224, ProPAC found that age groups explained very little of the variation in charges between the DRGs. Rather, they found complications and comorbidities and joint replacement procedures showed a significant difference in resources from all other cases in these DRGs.

Similarly, in DRGs 228 and 229, which are currently distinguished based on ganglion and cyst diagnoses, ProPAC found rheumatoid diagnoses, complications and comorbidities and joint replacement procedures more appropriate indicators of resource utilization.

We also have been studying these four DRGs throughout the year and have reached similar conclusions with regard to complications or comorbidities and joint procedures. We do not, however, agree with ProPAC's recommendation with regard to collagen vascular diseases in the hand. We note that in ProPAC's analysis of DRGs 228 and 229, the addition of collagen vascular diseases decreased the amount of explained variation by 16 percent. Further, the addition of this diagnosis (1328 cases) reduced the mean standardized charge for the DRG by five percent. We believe the commingling of uncomplicated rheumatoid cases with complicated cases and expensive joint replacement procedures would detract from the homogeneity of the revised DRGs. We should point out that ProPAC did not recommend classification of rheumatoid cases into the more resource-intensive DRG in upper extremity procedures except humerus and hand where inclusion of these diagnoses similarly reduced the amount of explained variation by almost ten percent. Moreover, as part of our analysis we have found that other major joint procedures, such as arthrodesis and arthrotomy are similar, both clinically and in resource utilization, to joint procedures involving a prosthesis. Consequently, we are proposing to expand upon ProPAC's recommendation to include major joint procedures with the joint prosthesis procedures included in the more resource-intensive classification. We are proposing to establish the following classifications in MDC 8:

DRG 223: Major shoulder or elbow procedures, or other shoulder, elbow or forearm procedures with complications or comorbidities.

DRG 224: Shoulder, elbow or forearm procedures, except major joint

procedures, without complications or comorbidities.
DRG 228: Major thumb or joint procedures, or other hand or wrist procedures with complications or comorbidities.
DRG 229: Hand or wrist procedures, except major joint procedures, without complications or comorbidities.

Major elbow and shoulder procedures include the following procedure codes:

8011 Other arthrotomy of shoulder
8012 Other arthrotomy of elbow
8123 Arthrodesis of shoulder
8124 Arthrodesis of elbow
8181 Shouder arthroplasty with prosthesis
8183 Shoulder arthroplasty, not elsewhere classified
8184 Elbow arthroplasty with prosthesis
8185 Elbow arthroplasty, not elsewhere classified

These procedures would be eliminated from DRG 224. All other procedures currently in DRGs 223 and 224 would result in assignment to proposed DRG 223 only if a complication or comorbidity is also present.

Major wrist, thumb and hand procedures include the following procedure codes:

8013 Other arthrotomy of wrist
8014 Other arthrotomy of hand/finger
8171 Hand arthroplasty with prosthesis
8179 Hand arthroplasty, not elsewhere classified
8186 Carpal arthroplasty with synthetic prosthesis
8187 Wrist arthroplasty, not elsewhere classified
8261 Pollicization operation
8269 Other reconstruction of thumb

These procedures would be eliminated form DRG 229. All other procedures currently in DRGs 228 and 229 would result in assignment to the proposed DRG 228 only if a complication or comorbidity is also present.

In addition we noted that procedure code 8421, thumb reattachment, had inadvertently been omitted from the procedures classified in MDC 8. Therefore, we are proposing to add this procedure to DRGs 228 and 229.

Finally, ProPAC has included in this recommendation a suggestion that cases involving both a surgical foot or upper extremity procedure and a nonsurgical hip diagnosis be classified on the basis of the more resource-intensive hip diagnosis.

We believe this situation is one example of the generic problem that could occur in any of the MDCs which contain a medical DRG with a higher weight than the least resource-intensive surgical DRG. Although we recognize that this issue may appear problematic, the situation occurs very infrequently. For example, ProPAC found only 125 cases related to this hip fracture issue. We believe this problem needs to be studied in a broad spectrum with detailed analysis of the frequency of occurrence, cost impact and impact on the DRG logic system before any piecemeal changes are implemented. Therefore, we have deferred proposing any action on this recommendation at the present time.

VI. Other Required Information

A. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments that we receive by the date and time specified in the "Dates" section of this preamble.

B. Paperwork Reduction Act

Section 412.65(b) contains information collection requirements that are subject to Office of Management and Budget review under the Paperwork Reduction Act of 1980. A notice will be published in the **Federal Register** when approval is obtained. Other organizations and individuals desiring to submit comments on the information collection requirements should direct them to the agency official whose name appears in the preamble and to the Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Room 3208, Washington, D.C., 20503, ATTN: Desk Officer for HCFA.

C. List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Health facilities, Medicare.

42 CFR Chapter IV would be amended as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBCHAPTER B—MEDICARE PROGRAMS

I. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Subpart D is amended as follows:

Subpart D—Principles of Reimbursement for Providers, Outpatient Maintenance Dialysis, and Services by Hospital-Based Physicians

1. The authority citation for Subpart D is revised to read as follows:

Authority: Secs. 1102, 1122(d), 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, 1886, and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1(d), 1395Al(b), 1395g, 13959(a), 1395x(v), 1395hh, 1305rr, 1395ww, and 1395xx).

2. Section 405.401 is amended by revising paragraph (d)(2) to read as follows:

§ 405.401 Introduction.

* * * * *

(d) *Payment for inpatient hospital services.*

* * * * *

(2) For cost reporting periods beginning on or after October 1, 1983, payment to short-term general hospitals located in the 50 States and the District of Columbia for the operating costs of inpatient hospital services is determined prospectively on a per discharge basis under Part 412 of this chapter except as follows:

(i) Payment for capital-related, medical education, and kidney acquisition costs, and the costs of certain anesthesia services, is provided in § 412.113 of this chapter.

(ii) Payment to children's, psychiatric, rehabilitation and long-term hospitals (as well as separate psychiatric and rehabilitation units (distinct parts) of short-term general hospitals), which are excluded from the prospective payment system under Subpart B of Part 412 of this chapter, and to hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 405.463.

(iii) Payment to hospitals subject to a State reimbursement control system is described in paragraph (e) of this section.

* * * * *

3. Section 405.435 is amended by revising paragraph (b) to read as follows:

§ 405.435 Nonallowable costs related to certain capital expenditures.

* * * * *

(b) *Applicability.* Under the principle specified in paragraph (a) of this section, any costs related to capital expenditures including the expenditures described in

§ 412.65 of this chapter) the obligation for which was incurred by or on behalf of a provider subsequent to 1972 (except as described in paragraph (c) of this section), are not allowable if the Secretary has determined that the capital expenditures have not been submitted to the designated planning agency as required or that they have been determined to be inconsistent with the standards, plans, or criteria developed by the designated planning agency or other health planning agency in the State to meet the need for adequate health care facilities in the area covered by the plan or plans so developed (see §§ 100.101 through 100.109 of this title). Costs claimed by a provider in connection with capital assets that are donated or transferred to a provider are also subject to the application of such principle. Such principle also applies to the reasonable equivalent of that portion of any rental expense incurred pursuant to a lease or a comparable arrangement (and to any amounts deposited under the terms of such a lease or comparable arrangement in computing the return on equity capital) that would have been excluded had the provider acquired such a facility or equipment by purchase. The amounts excluded are not subject to reimbursement under any other provisions of Medicare.

* * * * *

4. In § 405.454, the introductory text of paragraph (j) is redesignated as paragraph (j)(1) and revised; current paragraphs (j)(1) through (j)(5) are redesignated as paragraphs (j)(2) through (j)(6) respectively; in newly redesignated paragraph (j)(2), the introductory text and paragraphs (j)(2)(i) through (j)(2)(iii) are revised; and paragraph (m) is revised to read as follows:

§ 405.454 Payments to providers.

* * * * *

(j) *Periodic interim payment method of reimbursement.* (1) *Applicability.*—(i) *Covered services furnished before July 1, 1987.* In addition to the regular methods of interim payment on individual provider billings for covered services, the periodic interim payment (PIP) method is available for Part A hospital and skilled nursing facility inpatient services and for both Part A and Part B home health agency services.

(ii) *Covered services furnished on or after July 1, 1987.* Effective with covered services furnished to beneficiaries on or after July 1, 1987, the PIP method, in addition to the other methods of interim payment on individual provider billings for covered services, is available only for the following:

(A) SNF services.

(B) Part A and Part B HHA services.

(C) Hospitals receiving payment in accordance with a demonstration project authorized under section 402(a) of Pub. L. 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Pub. L. 92–603 (42 U.S.C. 1395b–1 (note)), or a State reimbursement control system approved under section 1886(c) of the Act and Subpart C of Part 403 of this chapter, if that type of payment is specifically approved by HCFA as a part of the demonstration or control system.

(2) Any participating provider furnishing the services described in paragraph (j)(1) of this section that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method, beginning with the first month after its request that the intermediary finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least $25,000 a year computed under the PIP formula or, in the case of an HHA, either its estimated—

(A) Total Medicare reimbursement for Part A and Part B services is at least $25,000 a year computed under the PIP formula; or

(B) Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable cost.

(ii) The provider has filed at least one completed Medicare cost report accepted by the intermediary as providing an accurate basis for computation of program payment (except in the case of a provider requesting reimbursement under the PIP method upon first entering the Medicare program).

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis.

* * * * *

(m) *Prospective payments.* (1) *General rule.*—

(i) *Final payment.* For cost reporting periods beginning on or after October 1, 1983, hospitals subject to the prospective payment system are paid for Part A inpatient operating costs on a per discharge basis using prospectively determined rates. The amounts represent final payment based on the submission of a discharge bill. Unless the provisions of paragraphs (m)(2) through (m)(5) of this section apply, year-end retroactive adjustments are not made for prospective payment hospitals.

(ii) *Outlier payments.* Payments for outlier cases (described in Subpart F of Part 412 of this chapter) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.

(iii) *Other payments.* Medical education costs are reimbursed as described in § 405.421, and capital-related costs are reimbursed as described in § 405.414 or, effective with cost reporting periods beginning on or after October 1, 1986, are paid for as described in §§ 412.65 through 412.67 of this chapter.

(2) *Interim prospective payments per discharge.* (i) Prospective payment hospitals meeting the criteria in paragraph (j) of this section may elect to receive periodic interim payments for discharges occurring before July 1, 1987. Therefore, at the discretion of the intermediary, the hospital's prospective payments are estimated and made on a periodic interim basis (26 biweekly payments). These payments are subject to final settlement. Each payment is made two weeks after the end of a biweekly period of services, as described in paragraph (j)(5) of this section. Hospitals electing periodic interim payments may convert to payments on a per discharge basis at any time.

(ii) For the hospitals receiving periodic interim payments for inpatient operating costs, the biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount. These interim payments are reviewed at least twice during the reporting period and adjusted if necessary.

(iii) For purposes of determining periodic interim payments under this paragraph, the intermediary computes a hospital's estimated average propective payment amount by multiplying its transition payment rates as determined under § 412.70(c) of this chapter, but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(3) *Special interim payments for certain costs.* For the direct costs of medical education, which are not included in prospective payments but are reimbursed as specified in § 405.421, interim payments are made subject to final cost settlement. Interim payments for the estimated cost of approved medical education programs (applicable to inpatient costs payable under Part A

and for kidney acquisition costs in hospitals approved as renal transplantation centers) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments. Each payment is made two weeks after the end of a biweekly period of services, as described in paragraph (j)(5) of this section. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(4) *Special interim payments for the indirect costs of medical education.* Payments for the indirect costs of medical education (described in § 412.118 of this chapter) are paid based on an estimate of the total for the Federal portion of the diagnosis-related group revenue to be received in the current period. The total estimated annual amount of the adjustment is divided into 26 equal biweekly payments and included with other inpatient costs reimbursed on a reasonable cost basis. This estimate is subject to year-end adjustment. Each payment is made two weeks after the end of a biweekly period of services. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(5) *Special interim payments for unusually long lengths of stay.* For discharges occurring on or after July 1, 1987, a hospital may request an interim payment if a Medicare beneficiary's length of stay exceeds 45 days. The amount of the interim payment is equal to the hospital's Federal rate multiplied by the appropriate diagnosis-related group weighting factor. Only one interim payment per discharge is permitted.

5. Section 405.463 is amended by revising paragraph (b)(1) to read as follows:

§ 405.463 Ceiling on rate of hospital cost increases.

* * * * *

(b) *Cost-reporting periods subject to the rate of increase ceiling.* (1) Base period. Each hospital's initial ceiling will be based on allowable inpatient operating costs per case incurred in the 12-month cost reporting period immediately preceding the first cost reporting period subject to ceilings established under this section, except that, when the immediately preceding cost reporting period is a short reporting period (fewer than 12 months) the first 12-month period beginning on or after the date the hospital's exemption from the ceiling ends will be the base period.

* * * * *

II. Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. The authority citation for Part 412 is revised to read as follows:

Authority: Secs. 1102, 1122, 1871, and 1886 of the Social Security Act, as amended (42 U.S.C. 1302, 1320a-1(d), 1395hh, and 1395ww).

B. The Table of Contents of Part 412 is amended by adding the titles of new §§ 412.65 through 412.67 to Subpart D to read as follows:

Subpart D—Basic Methodology for Determining Federal Prospective Payment Rates

Sec.

* * * * *

412.65 Addition of capital payments into the Federal rates.
412.66 Federal capital-related rates beginning on or after fiscal year 1987.
412.67 Phase-in period and methodology for capital payments.

* * * * *

C. Subpart A is amended as follows:

Subpart A—General Provisions

1. Section 412.1 is amended by revising paragraph (a) to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* This part implements section 1886(d) of the Act by establishing a prospective payment system for inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983. Under the prospective payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system (generally, short-term, acute care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (capital-related costs for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, kidney acquisition costs incurred by hospitals with approved renal transplantation centers, direct costs of medical education, and, for cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987, the costs of qualified nonphysician anesthetists' services) is made on a reasonable cost basis. Additional payments are made for outlier cases, bad debts, and indirect medical education costs. Under the prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating costs incurred in furnishing inpatient services, and is at risk for operating costs that exceed its payment rate.

* * * * *

2. In § 412.2, the introductory text of paragraphs (c) and (d) is reprinted without change for the convenience of the reader; a new paragraph (c)(5) is added; and paragraph (d)(1) is revised to read as follows:

§412.2 Basis of payment.

* * * * *

(c) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

* * * * *

(5) For cost reporting periods beginning on or after October 1, 1986, capital-related costs as described in Subpart D of this part.

(d) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and paid for on a reasonable cost basis:

(1) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986, capital-related costs, and an allowance for return on equity, as described in §§ 405.414 and 405.429 of this chapter.

* * * * *

3. Section 412.10 is amended by revising paragraph (a) to read as follows:

§412.10 Changes in the DRG classification system.

(a) *General rule.* HCFA issues changes in the DRG classification system in a **Federal Register** notice at least annually. Except as specified in paragraphs (c) and (d) of this section, the DRG changes will be effective prospectively with discharges occurring on or after the same date the payment rates are effective.

* * * * *

D. Subpart B is amended as follows:

Subpart B—Hospital Services Subject to and Excluded from the Prospective Payment System

1. In §412.23, the introductory language in paragraph (c) is revised to read as follows:

§412.23 Excluded hospitals: Classifications.

* * * * *

(c) *Alcohol/drug hospitals.* If an alcohol/drug hospital meets the

following requirements, it is excluded from the prospective payment system for its cost reporting periods beginning before October 1, 1987, but no hospital is excluded for its cost reporting periods beginning during Federal fiscal years 1986 and 1987 unless it was excluded for its cost reporting period beginning during Federal fiscal year 1985:

* * * * *

2. In § 412.32, the introductory language is revised to read as follows:

§ 412.32 Distinct part alcohol/drug units: Additional requirements.

If a distinct part alcohol/drug unit meets the following requirements, it is excluded from the prospective payment system for its cost reporting periods beginning before October 1, 1987, but no unit is excluded for its cost reporting periods beginning during Federal fiscal years 1986 and 1987 unless it was excluded for its cost reporting period beginning in Federal fiscal year 1985:

* * * * *

E. Subpart D is amended as follows:

Subpart D—Basic Methodology for Determining Federal Prospective Payment Rates

1. Section 412.63 is amended by revising paragraph (a)(1) and adding paragraphs (b)(3), (c)(4), and (c)(5) to read as follows:

§ 412.63 Federal rates for fiscal years after Federal fiscal year 1984.

(a) *General rule.* (1) HCFA will determine a national adjusted prospective payment rate for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 (including an additional payment, effective with cost reporting periods beginning on or after October 1, 1986, for the incorporation of capital payments as described in § 412.65) involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and will determine a regional adjusted prospective payment rate for such discharges in each region, for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* * * *

(3) Effective with discharges occurring on or after October 1, 1986, a hospital classified as rural, as described in § 412.62(f), is deemed to be urban and receives the urban Federal payment amount if the county in which it is located meets the following criteria:

(i) The rural county is surrounded on all sides by urban counties.

(ii) The county was reclassified from an urban area to a rural area after April 20, 1983, as described in § 412.62(f)(1)(iv).

(iii) At least 15 percent of employed workers in the county commute to the central county of one of the adjacent urban areas.

(c) *Updating previous standardized amounts.*

* * * * *

(4) For fiscal years 1987 and 1988, HCFA standardizes the average standardized amounts by excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(5) For fiscal year 1987 onward, HCFA restandardizes the average standardized amounts by excluding an estimate of indirect medical education payments.

* * * * *

2. New §§ 412.65 through 412.67 are added to read as follows:

§ 412.65 Addition of capital payments into the Federal rates.

(a) *General rule.* Effective with cost reporting periods beginning on or after October 1, 1986, HCFA provides an amount for capital-related costs, in addition to the Federal rates, as determined in § 412.63, for each inpatient hospital discharge.

(b) *Requirements.* In order to receive full payment for the Federal portion of the capital-related prospective payment amount, a hospital with capital expenditures, as defined under section 1122(g) of the Act, obligated after September 30, 1986, must be located in a State that has an agreement with the Secretary pursuant to section 1122 of the Act as described in § 405.435 of this chapter, under the terms of which a planning agency—

(1) Submits findings and recommendations to the Secretary concerning health facility capital expenditures; and

(2) Recommends approval of capital expenditures initiated by the hospital in its cost reporting periods beginning on or after October 1, 1986.

(c) *Capital expenditures that are not approved.* Except as discussed in paragraph (d) below, if capital expenditures are not approved as required under paragraph (b) of this section, the Federal portion of the capital-related prospective payment amount is reduced by the percentage of the total disapproved capital expenditures divided by total hospital capital assets.

(d) *Exception.* If a hospital can demonstrate to the satisfaction of HCFA that no part of the asset for which a capital expenditure is not approved, as required under paragraph (b) of this section, is used in the provision of inpatient hospital services for which payment may be made under this part, the Federal portion of the capital-related prospective payment amount will not be reduced under paragraph (c) of this section.

(e) *Cost reporting periods beginning on or after October 1, 1986 through September 30, 1990.* For cost reporting periods beginning during the period October 1, 1986 through September 30, 1990, the capital payment amount is based on a combination of a hospital-specific capital-related rate and a Federal capital-related rate as determined in §§ 412.66 and 412.67.

(f) *Cost reporting periods beginning on or after October 1, 1990.* For cost reporting periods beginning on or after October 1, 1990, the capital payment amount is based on a Federal capital-related rate as determined in §§ 412.66(g).

§ 412.66 Federal capital-related rates beginning on or after fiscal year 1987.

(a) *Determining allowable base-year capital-related costs.* The Federal capital-related rate is determined by identifying the average capital-related costs, as described in § 405.414 of this chapter, using audited hospital cost reports from fiscal year 1983 for hospitals subject to the prospective payment system and reducing the costs, using fiscal year 1984 hospital cost reports, by an estimated amount for investment income derived from funded depreciation.

(b) *Updating the capital-related costs.* HCFA updates each amount determined under paragraph (a) of this section by—

(1) Updating from fiscal year 1983 through fiscal year 1986 using the calendar year annual rate of increase in the capital component of the market basket; and

(2) Projecting for fiscal year 1987 onward the applicable percentage change under § 412.63(e).

(c) *Standardizing the amounts.* HCFA standardizes each amount updated under paragraph (b) of this section for each hospital by—

(1) Adjusting for resource intensity in case mix among hospitals;

(2) Excluding an estimate of indirect medical education payments;

(3) Excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients; and

(4) Adjusting for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(d) *Computing urban and rural averages.* HCFA computes an average of the standardized amounts determined under paragraph (c) of this section for urban and rural hospitals, as defined in § 412.62(f), in the United States and for urban and rural hospitals in each region.

(e) *Reducing for value of outlier payments.* HCFA reduces each of the average standardized amounts determined under paragraph (d) of this section by a proportion equal to the proportion (estimated by HCFA) of the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under Subpart F of this part.

(f) *Application of blended percentages during the transition period.* For cost reporting periods beginning during the period October 1, 1986 through September 30, 1990, the amounts determined in paragraph (e) of this section are multiplied by the appropriate phase-in period percentages as described in § 412.67(b).

(g) *Federal capital-related payment.* The Federal capital-related payment equals the product of—

(1) The national and regional capital-related rate as determined under paragraphs (a) through (f) of this section and § 412.67(b); and

(2) The DRG weighting factor determined under § 412.60(b) for each discharge.

§ 412.67 Phase-in period and methodology for capital payments.

(a) *Phase-in period.* Except for new hospitals and sole community hospitals as described in paragraphs (f) and (g) of this section respectively, inclusion of payments for capital in the prospective payment rates is to be phased-in over a four-year period as described in paragraph (b) of this section. During this period, the capital payment amount is based on a combination of a hospital-specific capital-related rate, and a Federal capital-related rate as determined in § 412.66. At the end of the transition period (that is, for discharges occurring in a cost reporting period beginning on or after October 1, 1990), payment amounts are based on a Federal capital-related rate.

(b) *Blended percentages for capital-related rates.* The blends of the hospital-specific capital-related rates and the Federal capital-related rates are as follows:

(1) For discharges in cost reporting periods beginning on or after October 1, 1986 and before October 1, 1987, the blend is—

(i) 80 percent of the hospital-specific capital-related rate; and

(ii) 20 percent of the Federal capital-related rate.

(2) For discharges in cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988, the blend is—

(i) 60 percent of the hospital-specific capital-related rate; and

(ii) 40 percent of the Federal capital-related rate.

(3) For discharges in cost reporting periods beginning on or after October 1, 1988 and before October 1, 1989, the blend is—

(i) 40 percent of the hospital-specific capital-related rate; and

(ii) 60 percent of the Federal capital-related rate.

(4) For discharges in cost reporting periods beginning on or after October 1, 1989 and before October 1, 1990, the blend is—

(i) 20 percent of the hospital-specific capital-related rate; and

(ii) 80 percent of the Federal capital-related rate.

(5) The appropriate Federal capital-related rate is a combined regional and national rate and changes with the Federal fiscal year. For Federal fiscal year 1987, which begins October 1, 1986, the Federal capital-related rate is 50 percent regional and 50 percent national. For Federal fiscal year 1988, which begins October 1, 1987, the Federal capital-related rate is 100 percent national.

TABLES.—SUMMARY OF HOSPITAL-SPECIFIC AND FEDERAL PORTION PERCENTAGES FOR DETERMINING PHASE-IN PERIOD CAPITAL-RELATED RATES

Cost reporting period beginning on or after—	Hospital-specific capital-related percentage	Federal capital-related percentage
October 1, 1986	80	20
October 1, 1987	60	40
October 1, 1988	40	60
October 1, 1989	20	80
October 1, 1990		100

(c) *Methodology—Hospital-specific capital-related rate.* The hospital-specific capital-related rate is the total allowable capital-related costs, as determined by HCFA, for the hospital's cost reporting period occurring in Federal fiscal year 1986 as calculated by—

(1) Calculating the allowable capital-related costs in the base year and dividing the remaining costs by the hosptial's number of Medicare discharges in that period; and

(2) Adjusting the costs per discharge for resource intensity in case mix.

(d) *Hospital-specific capital-related payment.* The hospital-specific capital-related payment equals the appropriate phase-in period percentage described in paragraph (b) of this section multiplied by the lower of—

(1) The hospital-specific capital-related rate as determined under paragraph (c) of this section, updated for fiscal year 1987 onward using the applicable percentage change under § 412.63(e), multiplied by the DRG weighting factor determined under § 412.60(b) for each discharge, and totalled for the number of Medicare discharges in the applicable period: or

(2) The total actual allowable Medicare inpatient hospital costs for the applicable transition year.

(e) *Cost reporting periods less than 12 months:* If a hospital has less than a 12-month cost reporting period, the amount of costs determined for the hospital-specific capital-related rate, for purposes of paragraph (c)(2) of this section, is the capital-related cost from the latest and longest cost reporting period in the base-year period, calculated on a per discharge basis and adjusted appropriately to make the costs consistent with standard 12-month cost reports for the base year.

(f) *Payment rate for new hospitals.*

(1) A new hospital is paid solely on the basis of the Federal capital-related rate, as determined in § 412.66, during the phase-in period, and thereafter, if it meets either of the criteria in paragraphs (f)(2) and (f)(3) of this section.

(2) The hospital—

(i) Is newly participating in the Medical program (under previous and present ownership); and

(ii) Does not have a 12-month cost reporting period ending on or before September 30, 1986.

(3) The hospital is under new ownership and documents to the satisfaction of its intermediary that the ownership and occupancy rate requirements described in § 412.74(a)(2) are met.

(g) *Payment rate for sole community hospitals.* A hospital that meets the criteria in § 412.92(a) for classification as a sole community hospital receives capital-related payments on the basis of—

(1) 25 percent of the regional capital-related payment as determined under § 412.66; and

(2) 75 percent of the hospital-specific capital-related payment as determined under paragraph (c)(1) of this section.

E. In Subpart E, § 412.70, the footnote to paragraph (c) is revised to read as follows:

Subpart E—Determination of Transition Period Payment Rates

§ 412.70 General description.

* * * * *

(c) *Amount of blended portions.*[1]

* * * * *

F. Subpart F is amended as follows:

Subpart F—Payment for Outlier Cases

1. In §412.80, the introductory language of paragraph (a)(1(ii) is reprinted without change for the convenience of the reader; and paragraphs (a)(1) introductory language, (a)(1)(ii)(B), and (c) are revised to read as follows:

§ 412.80 General provisions.

(a) *Basic rule.* (1) Except as provided in paragraph (a)(2) of this section concerning transferring hosptials. HCFA provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by HCFA, to a hospital for covered inpatient hosptial services furnished to a Medicare beneficiary if either of the following conditions is met:

* * * * *

(ii) The beneficiary's length of stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to cost by applying a national cost/charge ratio, exceed the greater of the following:

* * * * *

(B) a fixed multiple of the Federal prospective payment rate. During the transition period, the Federal rate and the Federal capital-related rate are a combination of the national rates and regional rates as follows:

Federal fiscal year	Federal rate		Federal capital-related rate	
	Regional rate percentage	National rate percentage	Regional rate percentage	National rate percentage
October 1, 1983	100	0		
October 1, 1984	75	25		
October 1, 1985	75	25		
October 1, 1986	50	50	50	50
October 1, 1987	0	100	0	100

* * * * * * *

(c) *Relation to indirect medical education costs and hospitals that serve a disproportionate share of low-income patients.* The outlier payment amounts will be included in total DRG revenue for purposes of determining payments for indirect medical education costs under § 412.118(b) and hospitals that serve a disproportionate share of low-income patients under §412.106.

3. In § 412.82, paragraph (c) is revised to read as follows:

§ 412.82 Payment for extended length-of-stay cases (day outliers).

* * * * *

(c) The per diem payment made under paragraph (a) of this section is derived by first taking 60 percent of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rates (capital-related and noncapital-related) determined under Subpart D of this part by the geometric mean length-of-stay for that DRG. The resulting amounts are then multiplied by the applicable Federal portions (capital-related and noncapital-related) of the blend as follows:

FEDERAL NONCAPITAL-RELATED PORTIONS

Cost reporting periods beginning on or after	Federal portion (percent)
October 1, 1983	25
October 1, 1984	50
October 1, 1985:	
The first seven months of the cost reporting period	50
The remaining five months of the cost reporting period	55
October 1, 1986	75
October 1, 1987	100

FEDERAL CAPITAL-RELATED PORTIONS

Cost reporting periods beginning on or after	Federal capital-related portion (percent)
October 1, 1986	20
October 1, 1987	40
October 1, 1988	60
October 1, 1989	80
October 1, 1990	100

* * * * *

4. In § 412.84, paragraphs (g) and (i) are revised as follows:

§ 412.84 Payment for extraordinarily high-cost cases (cost outliers).

* * * * *

(g) The intermediary bases the cost of the discharge on 71 percent of the billed charges for covered inpatient services. The cost is adjusted further to exclude an estimate of indirect medical education costs, and payments for hospitals that serve a disproportionate share of low-income patients, and to include the reasonable charges for nonphysician services billed by an outside supplier in accordance with § 489.23(c)(3) of this chapter.

* * * * *

(i) The additional payment amount is derived by first taking 60 percent of the difference between the hospital's adjusted cost for the discharge (as determined under paragraph (g) of this section) and the threshold criteria established under § 412.80(a)(2). The resulting amounts are then multiplied by the applicable Federal portions (capital-related and noncapital-related) of the blend as indicated in § 412.82(c).

G. Subpart G is amended as follows:

Subpart G—Special Treatment of Certain Facilities

1. In § 412.92, the introductory language of paragraphs (a) and (a)(2) are reprinted without change for the convenience of the reader and paragraphs (a)(2)(ii) and (d) are revised to read as follows:

§ 412.92 Special treatment: Sole community hospitals.

(a) *Criteria for classification as a sole community hospital.* HCFA classifies a hospital as a sole community hospital if it is located in a rural area (as defined in § 412.62(f)), and meets one of the following conditions:

* * * * *

(2) The hospital is located between 25 and 50 miles from other like hospitals and meets one of the following criteria:

* * * * *

(ii) The hospital has less than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(2)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

* * * * *

(d) *Determining prospective payment rates for sole community hospitals.* For all cost reporting periods beginning on or after October 1, 1983, the prospective payment rates for sole community

[1] For purposes of this paragraph and § § 412.60(a)(1)(ii)(B) and 412.82(c), but not for purposes of determining blended portions for capital-related payments under § 412.67(b), see section 9102(d)(4) of Pub. L. 99-272 for special provisions concerning the transition period applicable to hospitals in the State of Oregon.

hospitals equal the sum total of the following payment rates:

(1) 75 percent of the hospital-specific base payment rate as determined under § 412.73;

(2) 25 percent of the appropriate regional prospective payment rate as determined under Subpart D of this part; and

(3) The capital-related payment rate as determined under § 412.67(g).

* * * * *

2. In § 412.96, the introductory language of paragraph (c) is reprinted without change for the convenience of the reader: paragraphs (c)(2) (d) and (e) are revised, and a new paragraph (h) is added to read as follows:

§ 412.96 Special treatment: Referral centers.

* * * * *

(c) *Alternative criteria for cost reporting periods beginning on or after October 1, 1985.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in § 412.62(f)) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

* * * * *

(2) *Number of discharges.*

(i) Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital's most recently completed cost reporting period, its number of discharges (excluding discharges from subprovider and newborn units) is at least equal to the number of discharges under either the national or regional criterion set forth in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (h) of this section.

(ii) Effective with cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Hospital Association, that is located in a rural area must have at least 3,000 discharges during its most recently completed cost reporting period to meet the number of discharges criterion. The 3,000 discharges benchmark is also used in evaluating an osteopathic hospital for purposes of the triennial review.

* * * * *

(d) *Payment to rural referral centers with 500 or more beds.* A hospital that meets the criteria of § 412.96(b)(1) will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 412.62(j) or § 412.63(f), and § 412.66(g), as adjusted by the hospital's area wage index.

(e) *Payment to all other rural referral centers.* For cost reporting periods beginning on or after October 1, 1984, a hospital that is located in a rural area and meets the criteria of § 412.96(b)(2) or (c) will be paid prospective payments per discharge based on the applicable urban payment rates as determined in accordance with § 412.62(j) or § 412.63(f), and § 412.66(g), as adjusted by the hospital's area wage index.

* * * * *

(h) *Methodology for calculating number of discharges criteria.* For purposes of determining compliance with the national or regional number of discharges criterion under paragraph (c)(2) of this section, HCFA calculates the criteria as follows:

(1) *National criterion.* Except as described in paragraph (h)(6) of this section, HCFA determines the annual number of admissions to non-Federal, acute-care general and other special hospitals and compares it to the 1981 annual number of admissions. The percentage of change between those two figures is used to update the 1981 national number of discharges criterion of 6,000.

(2) *Regional criterion.* HCFA calculates the median urban number of discharges for each census region by updating the 1981 regional criterion using the percentage of change that is calculated under paragraph (h)(1) of this section.

(3) *Source of data.* In making the calculations described in paragraphs (h)(1) and (h)(2) of this section, HCFA uses the most recent hospital admissions data available for the Federal fiscal year ending prior to the publication of the annual notice of prospective payment rates under § 412.8(b).

(4) *Effective date.* HCFA sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are compared to a hospital's number of discharges for its most recently completed cost reporting period in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(5) *Applicability of criteria to HCFA review of referral center status.* For purposes of the triennial review of a referral center's status as described in paragraph (f) of this section, the referral center's number of discharges for its most recently completed cost reporting period is evaluated using the updated discharge criteria published in the subsequent Federal fiscal year's notice of prospective payment rates.

H. Subpart H is amended as follows:

Subpart H—Payments to Hospitals under the Prospective Payment System

1. Section 412.113 is amended by revising paragraph (a) and adding a new paragraph (d) to read as follows:

§ 412.113 Payments determined on a reasonable cost basis.

(a) *Capital-related costs.* Payment for capital-related costs (as described in § 405.414 of this chapter) is determined on a reasonable cost basis for cost reporting periods beginning on or after October 1, 1983 and before October 1, 1986. During that period, the capital-related costs for each hospital must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate under §§ 412.70 through 412.73. For cost reporting periods beginning on or after October 1, 1986, capital-related costs are paid on a prospective basis as described in §§ 412.65 through 412.67.

* * * * *

(d) *Kidney acquisition costs incurred by hospitals with approved renal transplantation centers.* Payment for kidney acquisition costs incurred by hospitals with approved renal transplantation centers, as described in § 412.100, is made on a reasonable cost basis.

2. Section 412.125 is amended by revising paragraph (b) to read as follows (the introductory language of § 412.125 is reprinted without change for the convenience of the reader):

§ 412.125 Effect of change of ownership on payments under the prospective payment system.

When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

* * * * *

(b) Payment for capital-related costs (for reporting periods beginning before October 1, 1986) and bad debts, as described in §§ 412.113(a) and 412.115(a), respectively, will be made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

(Catalog of Federal Domestic Assistance Programs No. 13.773, Medicare-Hospital Insurance Program)

Dated: May 27, 1986.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: May 28, 1986.

Otis R. Bowen,

Secretary.

Addendum—Schedule of Standardized Amounts Effective With Discharges on or After October 1, 1986, and Update Factors and Target Rate Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 1986

I. Summary and Background

In this proposed rule, we are proposing changes in the methods, amounts, and factors for determining prospective payment rates for Medicare inpatient hospital services. In addition, we are proposing new target rate percentages for determining the rate-of-increase limits (target amounts) for hospitals excluded from the prospective payment system.

For hospital cost reporting periods beginning on or after October 1, 1986 and before October 1, 1987, except for sole community hospitals and hospitals located in the State of Oregon that are subject to the prospective payment system, each hospital's payment per discharge under the prospective payment system will be the sum of a Federal portion that is 75 percent of the Federal rate and a hospital-specific portion that is 25 percent of the hospital-specific rate (section 1886(d)(1)(C) of the Act as amended by section 9102 of Pub. L. 99-272). Sole community hospitals will continue to be paid on the basis of a rate per discharge composed of 75 percent of the hospital-specific rate and 25 percent of the applicable Federal regional rate. For hospitals located in the State of Oregon that are subject to the prospective payment system, each hospital's payment per discharge will be based on the Federal national rate (section 9102(d)(4) of Pub. L. 99-272).

We note that, while the changes to the hospital-specific portion of the prospective payment rate are determined on the basis of cost reporting periods, the changes to the Federal portion are determined on the basis of the Federal fiscal year (FY).

During FY 1987, except for the policy on hospitals located in the State of Oregon as described above and for sole community hospitals, the Federal rates will be comprised of a blend of 50 percent of the national rate and 50 percent of the appropriate regional rate as required by section 1886(d)(1)(D) of the Act (as amended by section 9102 of Pub. L. 99-272). (Sole community hospitals also receive special treatment for the Federal rates, that is, their Federal portion is based on 100 percent of the regional rate.) During the first year of the transition period (that is, FY 1984), the Federal rates were comprised solely of the regional rate. During the second and third years, FYs 1985 and 1986, the Federal rates are comprised of a blend of 25 percent of the national rate and 75 percent of the regional rate.

As discussed below in section II, we are proposing to make changes in the determination of the prospective payment rates. The method for determining these rates was described in the final rules listed at the beginning of the preamble of this proposed rule. The changes, to be applied prospectively, would affect the calculation of the Federal rates. As part of these changes, we would incorporate adjustments for the updated hospital market basket and additional adjustments as authorized under section 1886(e)(4) of the Act.

Section III, below, sets forth our proposed changes in determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in this preamble are presented at the end of this addendum.

II. Proposed changes to Prospective Payment Rates and DRG Weighting Factors for FY 1987

The basic methodology for determining Federal national prospective payment rates is set forth at § 412.63. Below we discuss the manner in which we are proposing to change some of the factors or methodology used for determining the prospective payment rates. The federal rate changes, including the updated market basket, the establishment of capital-related standardized amounts into the prospective payment system, the updated wage index and DRG weights, once issued as final, would be effective with discharges occurring on or after October 1, 1986.

In summary, we are proposing to establish the FY 1987 national and regional rates (that is, the standardized amounts set forth in Table 1 of the addendum) by—

- Restandardizing the hospital costs used to establish the rates to reflect the indirect costs of medical education as measured by the revised indirect medical education adjustment factor and to reflect payment adjustments to disproportionate share hospitals, per sections 9104(b) and 9105(b) of Pub. L. 99-272, and to reflect technical corrections to the wage index;
- Computing average capital-related costs per case per hospital and adjusting the costs per case to exclude the effects of case mix, indirect medical education costs, payment adjustments to disproportionate share hospitals, and cost-of-living differences for Alaska and Hawaii;
- Grouping the adjusted operating costs per case (labor-related, nonlabor related, and capital-related) to compute urban and rural, national and regional average standardized amounts;
- Reducing for the value of outlier payments;
- Updating the standardized amounts by 0.5 percent; and
- Making a further adjustment to the standardized amounts to reflect the savings from the change in the indirect medical education adjustment as required under section 9104(b) of Pub. L. 99-272.

A. Calculation of Adjusted Standardized Amounts

1. Standardization and Restandardization of Base-Year Costs

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital in order to set the payment rates for FY 1984. The preamble to the interim final rule, published September 1, 1983 (48 FR 39763), contained a detailed explanation of how base-year cost data were established and how they were used in computing the Federal rates.

Section 1886(d)(2)(C) of the Act required that the updated base-year per discharge costs be standardized for the FY 1984 rates in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These include case mix, differences in area wage levels, cost of living adjustments, and indirect medical education costs. Under other statutory authority, we are proposing to restandardize the base-year costs to reflect changes resulting from Pub. L. 99-272, as discussed below.

In the following sections we discuss how we are proposing to restandardize (or not restandardize) the base-year costs for the following variables:

- Hospital wage levels.
- Case mix.
- Indirect medical education costs.
- Cost of living for Alaska and Hawaii.
- Costs for hospitals that serve a disproportionate share of low-income patients.

For the benefit of the reader, we are also discussing in the following sections whether or not capital-related costs

would be standardized for each of the above variables. A more detailed discussion of the proposed standardization of capital-related costs is provided in section II of the preamble.

a. Adjustments for Variation in Hospital Wage Levels. Section 1886(d)(2)(C)(ii) of the Act requires that for each inpatient hospital discharge in FY 1984 we standardize the average cost per case of each hospital used to develop the separate urban and rural standardized amounts for differences in area wage levels. Section 1886(d)(2)(H) of the Act requires that the FY 1984 standardized urban and rural amounts be adjusted for hospital area wage levels by a factor (established by the Secretary) as part of the methodology for determining prospective payments to hospitals. To fulfill both requirements, we constructed a wage index to eliminate variations in the average cost per case.

In accordance with Part III of the preamble, we are proposing to use the rebased market basket as a basis for revising the labor and nonlabor portions. Thus, for each hospital, instead of 79.15 percent, we would use 75.04 percent as the labor portion when standardizing for area wage variations.

In response to the June 10, 1985 proposed rule, we adopted a HCFA gross wage index in developing the FY 1986 prospective payment rates as published in the September 3, 1985 final rule. However, as a result of congressional action, we postponed application of several provisions of the September 3, 1985 final rule until May 1, 1986, as we discussed in the preamble of this proposed rule.

As a result of section 9103 of Pub. L. 99–272, the HCFA wage index, which was published in the September 3, 1985 final rule and modified subsequently for corrections to the data, became effective with discharges occurring on or after May 1, 1986. We published the wage indexes in the May 6, 1986 interim final rule (51 FR 16778) that implements section 9103 of Pub. L. 99–272.

Section 9103(a) of Pub. L. 99–272 also eliminated retroactive implementation of the revised wage index.

As indicated above, the HCFA wage index values published in the September 3, 1985 final rule were developed from hospital wage and employment records for cost reporting periods that ended in calendar year 1982. In the June 10, 1985 proposed rule, we specificially solicited comments on how the HCFA wage index should be updated, once adopted. However, we received only a few comments in response to our solicitation. In the September 3, 1985 final rule we stated that, because further consultation with the hospital industry was necessary to determine the proper vehicle for updating the HCFA wage index on a regular basis, we were deferring a final decision on the updating method (50 FR 35666).

We are now in the process of collecting audited data, based on hospital cost reports for cost reporting periods beginning in FY 1984, in order to update the HCFA wage index. However, these data will not be available for analysis or use until after October 1, 1986, when the FY 1987 prospective payment changes are scheduled to take effect. In addition, as part of the revised form HCFA–339, we are also collecting wage and salary data from hospitals filing cost reports during calendar year 1986.

The HCFA wage index is the latest available measure of hospital wage levels that addresses the part-time employment deficiency inherent in the BLS data. Therefore, we propose to use this measure of hospital wage levels to calculate the FY 1987 prospective payment rates. Except for changes resulting from (1) changes in MSA designations that may occur, as described elsewhere in this document, and (2) the proposed change in the designation of the Flint, Michigan MSA for Medicare prospective payment system purposes, also described elsewhere in this document, the HCFA wage index values that appear in this proposed rule are based on the same data used to develop the wage indexes published in the May 6, 1986 interim final rule (51 FR 16778).

We are not proposing to standardize capital-related costs for area wage variations because capital-related costs represent a *nonlabor* component and are, therefore, not affected by area wage variations.

b. Variations in Case Mix Among Hospitals. Section 1886(d)(2)(C)(iii) of the Act requires that the updated FY 1984 amounts be standardized to adjust for variations in case mix among hospitals. The methodology used for determining the appropriate adjustment factor (that is, the case-mix index) is explained in the September 1, 1983 interim final rule (48 FR 39768–39771). A case-mix index has been calculated for each hospital based on 1981 cost and billing data.

Standardization, necessary to neutralize inpatient operating costs for the effects of variations in case mix, is accomplished by dividing the hospital's arerage cost per Medicare discharge by that hospital's case-mix index. Table 3a in the addendum to the September 1, 1983 inetrim final rule (48 FR 39847–39870) contains the case-mix index values used for this purpose.

Although we are not proposing to make any changes to the case-mix index for inpatient operating costs and, therefore, are not restandardizing the updated amounts for variations in case mix, we are proposing to standardize each hospital's allowable Medicare capital costs per case by a later case-mix index (that is, hospital case-mix indexes for Federal FY 1985) as one of the adjustments appropriate under the authority of section 1886(d)(5)(C) of the Act to incorporate capital into the prospective payment rates. This is the latest and most complete case-mix data available. It would be improper to use the same case-mix index that was used to standardize the 1981 operating costs since we now have this more recent data available. This case-mix index is designated as Table 3c in the addendum, and is applied for purposes of standardizing capital costs. (We are also providing a Table 3d in the Addendum (Average Case-Mix Index by Hospital Classification Group) for those hospitals without a specific case-mix index in FY 1985.) The case-mix indexes in Tables 3a and 3b of the September 1, 1983 interim final rule (48 FR 39847) continue to apply for purposes of standardizing the non-capital operating costs per case.

C. Indirect Medical Education Costs. Section 1886(d)(2)(C)(i) of the Act requires that the updated FY 1984 amounts be standardized for indirect medical education costs. Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals receive an additional payment for the indirect costs of medical education. Section 9104(a) of Pub. L. 99–272 revised section 1886(d)(5)(B) of the Act to reduce the education adjustment factor used to determine the indirect medical education payment from 11.59 percent to approximately 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1988. For discharges occurring on or after October 1, 1988, the adjustment factor is equal to approximately 8.7 percent. These factors are approximations because in addition to being reduced, the adjustment factor is no longer applied on a linear basis, but rather on a curvilinear or variable basis. An adjustment made on a curvilinear basis reflects a nonlinear cost relationship, that is, each absolute increment in a hospital's ratio of interns and residents to beds does not result in an equal proportional increase in costs. Therefore, the adjustment factors are only approximately 8.1 percent and 8.7 percent.

In the interim final rule of May 6, 1986 (51 FR 16788), we revised §412.118 to provide that for discharges occurring on or after May 1, 1986 and before October 1, 1988, the indirect medical education factor equals the following:

$$2 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1\right]$$

(Note that the exponent (.405) was printed incorrectly as .045 in the preamble to the May 6, 1986 interim final rule (51 FR 16776)).

For discharges occurring on or after October 1, 1988, the indirect medical education factor equals the following:

$$1.5 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.5795} - 1\right]$$

Section 9104(b) of Pub. L. 99-272 amended section 1886(d)(2)(C)(i) of the Act and provides that the standardized amounts be restandardized to reflect the changes made to the payment adjustment for indirect medical education under section 9104(a) of Pub. L. 99-272. Although section 1886(d)(2)(C) specifically refers to standardizing the FY 1984 amounts, we believe that the amended section 1886(d)(2)(C)(i) was intended to require that the FY 1984 amounts, which were standardized for indirect medical education costs, be restandardized in FY 1987 based on the section 9104(a) of Pub. L. 99-272 changes. Therefore, in establishing the standardized amounts used to determine the FY 1987 prospective payment rates, after adjusting each hospital's inpatient operating cost per discharge for inflation, differences in area wage levels, and case mix, we are proposing that we divide each teaching hospital's cost per discharge by 1.0 plus the individual hospital's indirect medical education adjustment factor as computed using the formula above which the law requires be used for discharges on or after May 1, 1986 and before October 1, 1988.

The following is an example of how we would calculate a hospital's indirect medical education factor for purposes of restandardizing the standardized inpatient operating amounts:

Step 1.—Calculate the ratio (r) of the number of interns and residents to beds based on data for cost reporting periods ending in calendar year 1981.

Assume r=.2, where $r = \frac{\text{Number of Interns and residents}}{\text{beds}}$

Step 2.—Calculate the percentage adjustment (in decimal format) according to the following formula: $2[(1+r)^{.405}-1]$.

Therefore, the indirect medical education adjustment equals: $2[(1+.2)^{.405}-1] = .15327$ or rounded to .1533.

Step 3.—Add the result from step 2 (.1533) to 1.0. .1533+1.0=1.1533.

Step 4.—Divide the result from step 3 into that hospital's cost per discharge.

We are proposing to standardize capital-related costs for indirect medical education costs using the same adjustment formula, as described in the example above, but based on intern and resident to bed ratios developed from FY 1984 data.

d. Cost-of-Living Factor for Alaska and Hawaii. Section 1886(d)(5)(C)(iv) of the Act authorizes the Secretary to provide for such adjustments to the payment amounts as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

Generally, these two States have higher levels of cost in comparison to other States in the nation. The high cost of labor is accounted for in the wage index adjustments discussed above. However, the high cost of living in these States also affects the cost of nonlabor items (for example, supplies and equipment). Therefore, in order to remove the effects of the higher nonlabor costs from the overall cost data (that is, for standardization purposes), the nonlabor portion of the average cost per Medicare discharge in hospitals located in Alaska and Hawaii is divided by an appropriate cost-of-living adjustment factor. Because the nonlabor portion has already been standardized for this adjustment, we are not proposing a further restandardization.

We are proposing to standardize the capital-related costs for the cost of living in Alaska and Hawaii using the most recent cost-of-living adjustment factor as described in Part II of the preamble.

e. Costs for Hospitals that Serve a Disproportionate Share of Low-Income Patients. Section 9105(b) of Pub. L. 99-272 amended section 1886(d)(2)(C) of the Act (which relates to FY 1984 rates) by adding a new section 1886(d)(2)(C)(iv) to provide that effective with discharges occurring on or after October 1, 1986 and before October 1, 1988, the updated amounts be standardized for the estimated additional payments made to hospitals that serve disproportionate shares of low-income patients. That is, although erroneously drafted as an amendment to the methodology for determining FY 1984 rates, we believe that the law was intended to require us to remove the effects of the payments made to disproportionate share hospitals from the costs used to establish the standardized amounts. For discharges occurring on or after October 1, 1988, we would no longer restandardize the standardized amounts for the estimated payments made to disproportionate share hospitals, since section 1886(d)(5)(F) of the Act does not authorize such payments for discharges after September 30, 1988.

Section 9105(a) of Pub. L. 99-272 added a new section 1886(d)(5)(F) to the Act to require that we make an additional payment for hospitals that serve a disproportionate share of low-income patients. In the interim final rule of May 6, 1986 (51 FR 16788), we added a new § 412.106 to implement this provision.

Section 1886(d)(5)(F)(i) of the Act provides that for discharges occurring on or after May 1, 1986 and before October 1, 1988, an additional payment must be made for each prospective payment hospital that meets one of the following criteria:

- During the hospital's cost reporting period, the hospital has a disproportionate patient percentage that is at least equal to—

—15 percent, if the hospital is located in an urban area and has 100 or more beds;

—40 percent, if the hospital is located in an urban area and has less than 100 beds; or
—45 percent, if the hospital is located in a rural area.

(Section 1886(d)(5)(F)(i)(I) of the Act.)

• The hospital is located in an urban area, has 100 or more beds, and can demonstrate that during its cost reporting period, more than 30 percent of its total inpatient care revenue is derived from State and local government payments for indigent care furnished to patients not covered by Medicare or Medicaid.

(Section 1886(d)(5)(F)(i)(II) of the Act.)

Under section 1886(d)(5)(F) of the Act, the additional payment adjustments for hospitals that meet the criteria of a hospital that serves a disproportionate share of low-income patients are determined as follows:

• For urban hospitals with 100 or more beds, the hospital's total DRG revenue is increased by 2.5 percent plus one-half the difference between the hospital's percentage of low-income patients and 15 percent, up to a maximum of 15 percent; that is, the disproportionate share adjustment factor is the lesser of 15 percent or $(P-15)(.5) + 2.5$, where P equals the hospital's disproportionate patient percentage expressed as a decimal.

• For urban hospitals with fewer than 100 beds, the hospital's total DRG revenue is increased by five percent.

• For rural hospitals, the hospital's total DRG revenue is increased by four percent.

• For hospitals that qualify for disproportionate share adjustments based on a certain proportion of their revenue coming from State and local sources for indigent care, the hospital's total DRG revenue is increased by 15 percent.

Therefore, in establishing the standardized amounts for FY 1987, we are proposing to adjust each disproportionate share hospital's inpatient operating cost per discharge by adding 1.0 to the applicable disproportionate share payment factor, and dividing the hospital's cost per discharge by that number. In this way we would remove the effect of payment adjustments for disproportionate share hospitals from the standardized amounts as required under section 1886(d)(2)(C)(iv) of the Act.

In determining the disproportionate share adjustment factors for purposes of standardizing the standardized amounts, we would use available data on the percentage of Medicaid days from Medicare costs reports with cost reporting periods beginning in Federal FY 1984 and the percentage of SSI/Medicare days for FY 1984 derived from matchaing FY 1984 SSI eligibility files to Medicare FY 1984 PATBILL records.

In accomplishing such standardization for this proposed notice, we have not taken into acccount any payments to hospitals that qualify for disproportionate share payments based on the percentage of their revenue from State and local government sources for indigent care. This is because these hospitals must demonstrate on a hospital-by-hospital basis that they meet the criteria for a payment adjustment. Since the disproportionate share hospital provision has been in effect only since May 1, 1986, we do not know at this time how many or which hospitals will ultimately qualify under this provision. While the number of such hospitals may be small, and therefore may not have a significant effect on the standardized rates, we will monitor this situation closely, and, to the extent possible, will present our data and analysis in the final rule. We plan to restandardize the rates to take account of payments to these hospitals in the final rule.

We are proposing to standardize capital-related costs for the costs of hospitals that serve a disproportionate share of low-income patients in the same manner that we are standardized the standardizing inpatient operating amounts.

It should be noted that, to standardize both the capital-related and operating costs for the effects of indirect medical education costs and disproportionate share payments, we added the adjustments together and divided the cost per discharge by the resulting sum. We did this in order to remain consistent with the manner in which the additional payments for indirect medical education and disproportionate share are made.

2. Grouping of Urban/Rural Averages Within Geographic Areas

Under section 1886(d)(2)(D) of the Act, the average standardized amounts must be determined for hospitals located in urban and rural areas of the nine census divisions and the nation. For FY 1987, except for sole community hospitals and hospitals in Oregon, the Federal rates will be comprised at 50 percent of the national rate and 50 percent of the regional rate (section 1886(d)(1)(D) of the Act). Therefore, Table 1 contains 20 standardized amounts (ten urban amounts and ten rural amounts further divided into labor-related, nonlabor-related, and capital-related portions). The methodology for computing the national average standardized amounts is identical to the methodology for determining the regional amounts, except that the national urban and rural groups include hospitals from all urban and all rural geographic areas, respectively.

The Executive Office of Management and Budget (EOMB) may announce revised listings of the MSA and New England County Metropolitan Area (NECMA) designations that are used in calculating the standardized amounts. If EOMB makes the announcement before we issue the final rule, we will list the revised MSA/NECMA designations in the addendum to the final rule. The changes in designation will apply beginning in FY 1987.

3. Updating the Average Standardized Amounts

a Statutory Requirements. The basic requirements governing the method by which the average standardized amounts are updated are set forth at section 1886(d)(3)(A) of the Act, as follows:

(A) Updating Previous Standardized Amounts.—The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased for each of fiscal years 1985 and 1986 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to adjust the urban and rural average standardized amounts using the applicable percentage as determined by the Secretary in accordance with section 1886(e)(4) of the Act. That section reads as follows:

(4) Taking into consideration the recommendations of the Commission [that is, the Prospective Payment Assessment Commission, or ProPAC], the Secretary shall determine for each fiscal year (beginning with fiscal year 1987) the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

As prescribed by section 1886(e)(2) of the Act, the Commission, in making its recommendations to the Secretary:

Shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain

quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

Section 1886(b) of the Act sets forth the requirements under which a rate of increase limit (target amount) is established for the inpatient operating costs of hospitals excluded from the prospective payment system. Under this section, a target amount is determined annually for each hospital cost reporting period, based on each hospital's base year cost per case, updated by an "applicable percentage increase."

For FYs 1987 and 1988, as required under 1886(b)(3)(B)(i)(II) of the Act, the "applicable percentage increase" is determined by the Secretary pursuant to section 1886(e)(4) of the Act and may not exceed the "market basket percentage increase" defined in section 1886(b)(3)(B)(ii) as:

> With respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.

We have used the hospital market basket as the means to measure the change in the cost of goods and services for both prospective payment rates and the target amounts applicable to hospitals and units excluded from the prospective payment system. Under section 1886(b)(3)(B) of the Act as amended by section 9101(b) of Pub. L. 99-272, for FY 1987 the percentage determined by the Secretary under section 1886(e)(4) would be applied to both the prospective payment rates and the target amounts (rate of increase limits) applicable to hospitals and units excluded from the prospective payment system.

b. Factors Considered in Determining the Proposed FY 1987 Update. As is clear from the discussion of the legal requirements for establishing the FY 1987 update, we must consider at least the following factors in addition to the hospital market basket index:

- Hospital productivity.
- Cost-effective technologies.
- Improvements in practice patterns.

In addition, since the standardized amounts for FY 1986 are used as the basis for the determination of rates for later years, we believe the level of the FY 1986 standardized amounts must be corrected for any experience that has developed since they were published. In short, we believe that it is necessary, each year, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries. Further, this review must include an assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care. In this way we would avoid carrying forward inaccuracies in the previous year's rates into the future and, thus, avoid overpaying or underpaying hospitals as a result of those inaccuracies.

Therefore, we believe that the FY 1987 standardized amounts should be established by a methodology that takes into account the prior year's experience (whether understated or overstated). To this end, we have measured the observed change in case mix to be 2.7 percent. We estimate that 0.6 percent of the observed change is for real increases in case-mix, and thus 2.1 percent is for improved coding practices for FY 1986 as discussed in section II.A.3.c., below. The market basket forecast error (−0.4 percent) for FY 1986 is discussed in section II.A.3.d., below, that contributed to an overstatement of the FY 1986 standardized amounts. We are proposing to reduce the FY 1987 prospective payment rates accordingly.

In addition, we have developed factors representing allowances or offsets for productivity, technological advances, and improvements in practice patterns that are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Taking into consideration ProPAC's recommendations on the policy target adjustment factor, we have determined an appropriate percent value for each of these factors, making conservative assumptions with regard to their potential effect on quality, and have combined these values into a proposed composite policy target adjustment factor, as discussed in section II.A.3.f., below. For FY 1987, the factor would equal −2.0 percent.

The forecast hospital market basket increase for FY 1987 is +3.6 percent. With the offsets for net case-mix change from FY 1986 (−2.1 percent), forecast market basket error in FY 1986 (−0.4 percent), and the composite policy target adjustment factor (−2.0 percent), we believe there is justification for a 0.9 percent decrease in the FY 1987 standardized amounts, as compared to those FY 1986.

c. Nominal Case-mix Change for FY 1986. We believe it is necessary to update the standardized amounts to take into consideration the overstatement in case mix as a result of improved coding practices. Through such an adjustment we would ensure that we are providing the amounts necessary for the efficient and effective delivery of medically needed health care. Not taking such overstatement into account would result in overpayments to hospitals, since the increased case mix would not be related to actual increases in resource use. As part of our prospective payment monitoring system, we have been generating monthly case-mix index values for each hospital under the prospective payment system. Based on hospital bills received through April 1986, which include about 2.7 million discharges in FY 1986 for prospective payment system hospitals in States which did not have waivers in FY 1985, we have observed that hospital case-mix index values have increased an average of 2.7 percent over the comparable period in FY 1985. We intend to use the latest discharge data available to us in the final rule in determining the change in case mix over the FY 1985 period.

To determine the degree of difference, we computed a separate case-mix index for each hospital for each month in which we received bills by multiplying the number of discharges for each DRG by the relative weight for that DRG, summing the products, and then dividing that sum by the number of total discharges for that month and hospital. The discharge weighted average prospective payment case-mix index for all hospitals and months in the file for FY 1986 was 1.1983.

We then computed a comparable average case mix for FY 1985. This was done by computing a case-mix index for each hospital, for each month in FY 1985 and determining a weighted average of the monthly case-mix averages using the FY 1986 discharges already reported to us through March 1986 as weights.

This automatically excludes data for FY 1986 months for which we have no bills. This also compensates for any biases that could have been due to seasonal variations, and the timeliness of submitting bills. Hospitals in States with Medicare waivers (New York and Massachusetts) in 1985 were excluded from this analysis so that the case-mix increase was measured only for hospitals under the prospective payment system for both FY 1985 and FY 1986.

The comparable case-mix level for FY 1985 was 1.1670.

We then computed the ratio of the average FY 1986 case-mix index to the FY 1985 case-mix index. This ratio is 1.027 (1.1983 divided by 1.1670 equals 1.027). ProPAC recommended a 1.0 percent reduction in the prospective payment rates for observed case mix based on the latest data available to them. Our data, which indicate a 2.7 percent decrease is justified, are more recent, and we believe our proposed adjustment coincides with ProPAC's recommendation for observed nominal case-mix changes due to improved coding.

d. Correction for Forecast Market Basket Error for FY 1986. The forecast hospital market basket increase factors used to calculate the FY 1986 standardized amounts were 4.8 percent for 1985 and 4.1 percent for 1986. Based on these calendar year factors, we projected a hospital market basket increase factor for FY 1986 of 4.27 percent. Our latest hospital market basket factors, as of April 1986 (which do not include a value for capital-related costs, as described in section II of the preamble, nor are the factors rebased or reweighted, as described in section III of the preamble) reflect more actual experience than those available at the time the FY 1986 rates were published. The most recent factors are 4.6 percent for 1985, 3.6 percent for 1986, and 4.1 percent for 1987. Based on these calendar year factors, we project the hospital market basket increase for FY 1986 should have been 3.85.

FORECAST MARKET BASKET (MB) PERCENT INCREASE FY 1986 RATES AND OUR MORE RECENT FY 1986 DATA

Calendar year	Forecast MB percentage	Updated MB percentage
1985	4.8	4.6
1986	4.1	3.6
1987	4.8	4.1

Using the latest market basket factors for correction of the standardized amounts, we would reduce them by 0.4 percent (4.27 percent minus 3.85 percent equals 0.42 percent). We expect to have even more recent and accurate factors available at the time we publish final FY 1987 standardized amounts, and will use those factors in making corrections to the standardized amounts.

e. *Forecast Market Basket Increase.* We must consider forecasted market basket increases in determining the percentage increase for both prospective payment rates and rate-of-increase limits (target amounts) for FY 1987. However, the percentage change determined under section 1886(e)(4) of the Act does not have to equal the market basket. Rather, the percentage change, or update factor, may not exceed the increase in the market basket. We note that this market basket. We note that this market basket would include a capital component in addition to being updated using a more recent base year (rebased), and additional cost categories (reweighted and revised price proxies).

FORECAST MARKET BASKET (MB) PERCENTAGE INCREASE

	MB percentage
Calendar year:	
1986	3.2
1987	3.7
1988	4.9

Based on these calendar year factors, we project a hospital market basket increase factor for FY 1987 (that is, October 1, 1986 to September 30, 1987) of 3.6 percent.

Data Resources, Inc. (DRI) provides HCFA the historical and forecasted rates of increase in the market basket cost categories. Anyone interested in obtaining additional information on these forecasts may contact Data Resources, Inc., 1750 K Street, NW., 9th Floor, Washington, DC 20006. Upon request DRI will provide in writing a description of the general methodology as well as all of the variables used in the market basket forecast model.

f. Composite Policy Target Adjustment Factor—(1) General considerations. In analyzing the prospective payment system, we must consider the effects of the rates we set on outcome measures such as quality and access to care, and the financial viability of the hospital industry insofar as it relates to beneficiary access to high quality care.

(a) Quality of and Access to Care. We have not found any evidence of compromise or deterioration in the quality of, or access to, inpatient hospital care for Medicare beneficiaries since the inception of the prospective payment system. In conjunction with our own studies on quality and access, we have monitored ProPAC's activity on quality and access assessments. Available data and study findings on subjects such as mortality trends and readmission rates do not indicate any negative findings regarding a deterioration in quality or access under the prospective payment system. Furthermore, we believe our commitment to high quality care and access are evident in the monitoring functions of the peer review organizations and the implementation of procedures to ensure that beneficiary rights are maintained so that beneficiaries are protected against premature discharges as discussed in section V of the preamble.

(b) Financial Viability of the Hospital Industry. Profitability measures of the hospital industry have received much attention recently. We believe that it is *not* our responsibility to determine specific levels of appropriate hospital profit margins. However, since Medicare inpatient hospital benefit payments represent over 40 percent of total community hospital inpatient revenues, Medicare should be a prudent purchaser of services furnished under the prospective payment system. A review of financial information is appropriate in order to determine how well the hospital industry has done before and after the inception of the prospective payment system. Our concern with the financial viability of the hospital industry does not extend beyond ensuring that high quality hospital care is accessible to Medicare beneficiaries.

ProPAC has conducted a number of studies on the financial condition of hospitals in 1984 (see "Medicare Prospective Payment and the American Health Care System," Chapter 4, page 47, Report to Congress, February 1986). According to hospital industry financial data, operating margins increased significantly. Although rural hospitals had the lowest profit margins, they experienced large profitability gains in the first year of the prospective payment system. These findings also showed that both teaching and nonteaching hospitals experienced large gains in operating margin ratios.

In addition, the Department's Office of the Inspector General has released a priority audit memorandum titled, "Large Profits Earned by Hospitals under the Medicare Prospective Payment System" (ACN: 09-62021), which confirms ProPAC's findings.

Table 1 below contains AHA panel survey data on operting margins, for both total revenue and patient care revenue, of community hospitals for FY 1983, 1984, and 1985. The operating margins are shown for each AHA geographic region (which correspond to the census regions used in establishing the prospective payment rates). Table 2 below contains comparable national data for calendar years 1974–1984. It should be noted that these substitutes for profit margins should be used cautiously. For example, net operating revenues in the 1970s indicate large losses in the industry, but this is

because patient revenue only is compared with *total* hospital expenses. This is not a valid comparison but is, nevertheless, the one which the hospital industry frequently makes. More relevant in this analysis is how well hospitals did prior to and after the inception of the prospective payment system, using these measures as a guide.

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Table 1: Total Margin of Community Hospitals by Region, FYs 1983-85

Net Revenue as a Percentage of Total Revenue

Region	Fiscal Year 1983	1984	1985
U.S. Total	5.3	5.7	6.3
New England	3.0	4.1	5.5
Middle Atlantic	1.0	1.2	2.6
South Atlantic	6.4	7.3	7.5
East North Central	5.2	5.5	6.3
East South Central	6.7	7.0	8.2
West North Central	5.2	5.6	6.0
West South Central	8.3	8.1	7.5
Mountain	7.0	5.0	6.2
Pacific	7.0	8.3	8.2

Net Patient Revenue as a Percentage of Total Patient Revenue

Region	Fiscal Year 1983	1984	1985
U.S. Total	1.1	1.4	1.9
New England	-1.2	0.0	1.4
Middle Atlantic	-3.9	-3.4	-2.1
South Atlantic	1.7	2.6	2.2
East North Central	1.3	1.5	2.3
East South Central	1.6	1.9	3.3
West North Central	1.1	0.8	1.2
West South Central	4.7	4.0	3.2
Mountain	3.6	1.3	2.1
Pacific	3.6	4.9	4.7

SOURCE: American Hospital Association National Panel Survey Report

Table 2

Total Margin of Community Hospitals
Calendar Years 1974-1984

Year	Total Revenue (dollars)	Total Expenses (dollars)	Net Total Revenue		
			Amount (dollars)	Percent of Expenses	Percent of Revenue
1985	142,520,977	134,042,796	8,478,181	6.3	5.9
1984	134,331,178	126,027,583	8,303,595	6.6	6.2
1983	126,728,291	120,219,622	6,508,669	5.4	5.1
1982	114,954,728	109,091,340	5,863,388	5.4	5.1
1981	98,812,788	94,187,000	4,625,788	4.9	4.7
1980	83,122,087	79,339,633	3,782,454	4.8	4.6
1979	70,599,829	67,832,712	2,767,117	4.1	3.9
1978	62,011,648	59,802,346	2,209,302	3.7	3.6
1977	54,992,929	53,006,115	1,986,814	3.7	3.6
1976	47,324,028	45,842,045	1,481,983	3.2	3.1
1975	39,400,855	38,492,033	908,822	2.4	2.3
1974	33,460,394	32,759,261	701,133	2.1	2.1

Operating Margin of Community Hospitals
Calendar Years 1974-1984

Year	Patient Revenue (dollars)	Total Expenses (dollars)	Net Operating Revenue		
			Amount (dollars)	Percent of Expenses	Percent of Revenue
1985	136,022,058	134,042,796	1,979,262	1.4	1.4
1984	128,547,733	126,027,583	2,520,150	2.0	2.0
1983	121,383,083	120,219,622	1,163,461	1.0	1.0
1982	109,889,658	109,091,340	798,318	0.7	0.7
1981	94,338,041	94,187,000	151,041	0.2	0.2
1980	79,543,945	79,339,633	204,312	0.3	0.3
1979	67,433,807	67,832,712	(398,905)	-0.6	-0.6
1978	59,311,319	59,802,346	(491,027)	-0.8	-0.8
1977	52,689,901	53,006,115	(316,214)	-0.6	-0.6
1976	45,166,323	45,842,045	(675,722)	-1.5	-1.5
1975	37,358,705	38,492,033	(1,133,328)	-2.9	-3.0
1974	31,586,183	32,759,261	(1,173,078)	-3.6	-3.7

SOURCE: Actuarial Note 85-01, July 29, 1985, American Hospital Association, National Panel Survey

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Without attempting to determine an appropriate level of profitability, it is clear that hospital operating margin for both total revenue and patient revenue recorded historic highs during the first two years of the prospective payment system. Analyses of geographic distributions of hospital profit margin yield some interesting observations. The Middle Atlantic region showed the lowest level of operating margins. This region consists of Pennsylvania, New York, and New Jersey, the latter two being States that were paid under alternative reimbursement programs during the periods shown. The New England region had the second lowest level of operating margins, and the largest State in that region, Massachusetts, also was paid under an alternative reimbursement program during the periods shown. In comparing changes in operating margin between FYs 1983 and 1985, it is interesting to note that the range of operating margin across the regions has narrowed.

Some have argued that overall hospital profitability gains are in spite of, rather than a result of, the prospective payment system. They assert that inadequate Medicare payments have resulted in cost shifting to the private insurance industry. Our actuarial studies effectively rebutted that assertion in Actuarial Note 85-01, "Exploding the Cost Shifting Myth," released on July 29, 1985. Table 3 below contains data on AHA and Medicare inpatient hospital experience for days of care, revenues, and benefit payments. The data indicate no evidence of cost shifting and suggest further that hospitals have fared quite well under the prospective payment system. Data are shown for each calendar year 1978-1985, on the ratio of Medicare inpatient days of care to total hospital days used, and the ratio of Medicare benefit payments and beneficiary liabilities to total community hospital inpatient revenue. During 1984 and 1985, the ratio of Medicare days to total hospital days *decreased* by 7.8 percent. At the same time, the ratio of Medicare benefit payments and beneficiary liabilities to total hospital inpatient revenue *increased* by 10.4 percent. If cost shifting to the private sector was occurring, the Medicare share of revenues would decrease faster than the the Medicare share of days.

TABLE 3.—MEDICARE SHARES OF TOTAL COMMUNITY HOSPITAL INPATIENT DAYS AND EXPENDITURES, CALENDAR YEARS 1978-85

	Days of Care				Expenditures (in millions)					
Calendar Year	Medicare Inpatient Days	Total AHA Inpatient Days	Ratio of Medicare to Total Days	Percent Change	Medicare Inpatient Benefit Payments	Beneficiary Deductible and Coinsurance	Total Medicare and Beneficiary Payments	Total AHA Inpatient Revenue	Ratio of Medicare Payments to Total Inpatient Revenue	Percent Change
1978	102,300	256,708	0.399		$16,943	$1,229	$18,172	$51,703	0.351	
1979	105,881	260,792	0.406	1.9	19,775	1,425	21,200	58,712	0.361	2.7
1980	112,685	269,615	0.418	2.9	24,082	1,707	25,789	69,140	0.373	3.3
1981	116,326	272,957	0.426	2.0	29,071	1,970	31,041	81,764	0.380	1.8
1982	116,304	271,422	0.428	0.5	33,909	2,557	36,466	95,037	0.384	1.1
1983	115,120	264,504	0.435	1.6	37,208	3,057	40,265	104,361	0.386	0.6
1984	101,073	241,780	0.418	−4.0	40,713	3,509	44,222	109,145	0.405	5.0
1985	90,965	226,129	0.402	−3.8	44,475	3,813	48,288	113,061	0.427	5.4

Sources: Medicare—Office of the Actuary, Health Care Financing Administration. AHA Panel Survey for Community Hospitals through December 1985.

Note.—Medicare data represent total inpatient hospital experience. Short-stay hospitals represent about 95 percent of total Medicare inpatient days and about 98 percent of total inpatient Medicare benefit payments.

Presented in Table 4 below are further data indicating that the prospective payment system is not adversely affecting the financial viability of the hospital industry. Although charge data themselves are not a true reflection of hospital costs, the ratio of medicare expenditures to charges over time shows some interesting trends. Both the ratios of total program payments and program payments plus Medicare beneficiary liabilities to hospital charges reversed decreasing trends and showed significant increases in the first two years of the prospective payment system.

TABLE 4. ESTIMATED RATIOS OF MEDICARE EXPENDITURES TO TOTAL CHARGES. SHORT-STAY HOSPITAL IMPATIENT CARE, FY 1980-85

Fiscal Year	Billed Payments	Retroactive Adjustments [1]	Pass throughs [2]	Total Program Payments	Beneficiary Liabilities [1]	Total Program and Beneficiary Expenditures
1980	.688	.031		.719	.052	.771
1981	.678	.029		.706	.050	.756
1982	.662	.023		.685	.055	.740
1983	.638	.026		.662	.056	.718
1984	.649	.012	.036	.698	.061	.757
1985 (total)	.672	.010	.087	.769	.060	.829
(PPS only)	.687	[3] N.A.	102	[3] N.A.	[3] N.A.	[3] N.A.

[1] Includes total inpatient expenditures. Short-stay hospitals represent 98 percent of total inpatient benefit payments.
[2] Includes capital and medical education payments.
[3] N.A.-not available.
Source: Bureau of Data Management and Strategy and Office of the Actuary. HCFA.

(c) *Summary.* In determining the update level for the FY 1987 prospective payment rates, the above evaluation of outcome measures attempts to measure current and prospective effects on taxpayers, beneficiaries, and the industry.

- *Beneficiary Perspective* —There is not evidence of a deterioration in quality of, or access to, inpatient hospital care.
- *Industry Perspective*—Experience under the prospective payment system shows evidence that current Medicare payments for inpatient hospital care are more than adequate to cover hospital costs.
- *Prior Year's Experience*—Despite our calculation showing that the prospective payment rates should have been decreased by 4.42 percent in FY

1986 (as described in the September 3, 1985 final rule (50 FR 35693)) we provided a zero percent increase, and subsequently Congress provided a 0.5 percent increase in the rates.

The annual prospective payment percentage update factor should be set so that it provides incentives for desired outcomes under the prospective payment system. To achieve incentives for the desired outcome targets, we must ensure that the annual prospective payment update factor takes proper account of variables affesting the cost, efficiency, effectiveness and quality of hospital inpatient care. Our objective is to translate the intent of the statutory requirements for updating the prospective payment rates into a methodology for making adjustments to the current update factory that would enable us to express our consideration of these variables as policy targets.

To this end, we have identified three factors that correspond to matters that must be considered under section 1886(e)(2) and (e)(4) of the Act. For FY 1987, we are proposing to incorporate into the prospective payment update factor a composite policy target adjustment factor that takes account of productivity, cost-effective technologies, and improvements in practice patterns. Although, as we discuss below, we have changed the descriptive title of the third factor (from "elimination of cost-ineffective practice patterns" to "improvements in practice patterns"), the three factors are the same as those we identified in the September 3, 1985 final rule (50 FR 35705). While, for the purposes of analysis and discussion, we have developed separate values for each of these three factors, we are proposing to combine them into a composite policy target adjustment factor, which would be considered in determining the FY 1987 prospective payment update factor.

(2) Productivity. As was the case last year, there does not exist and aggregate hospital industry productivity measure that can be used to interpret the intent of sections 1886(e)(2) and (e)(4) of the Act. The Bureau of Labor Statistics (BLS) is currently constructing a hospital productivity measure based on discharges adjusted for case-mix. The BLS index measures adjusted admission per employee in non-Federal, short-stay hospital. However, the BLS measure is an index of discharges per employee and not an overall operating input productivity index.

In setting the FY 1986 policy target adjustment factor, we considered productivity in terms of the ratio of real input to hospital outputs, where outputs are defined as the various tests, procedures, and services provided by the hospital. (In contrast, ProPAC defines output in a more inclusive fashion, so as to include changes in practice patterns.) We pointed out that national productivity increases over the economy as whole had averaged three percent per year in 1983 and 1984, and that after years of cost-based reimbursement, hospitals should be able to achieve a reduction imputs of at least that amount. The argument was that hospitals ought to be able to equal the national average for productivity increaes in the future because, with fixed and known payment rates, they could adjust their inputs to eliminate unnecessary costs. The FY 1986 productivity factor was set at one percent. This target was set conservatively because of uncertainty with regard to achievable productivity gains.

A primary objective of the prospective payment system is to encourage the efficient provision of hospital care by changing economic incentives under the payment system. It is reasonable to assume that hospitals have (or should have) made substantial productivity grains during the first thre years of the prospective payment system. The only adjustment that we have made to DRG prices for any such productivity gains was the one percent offset used in updating the FY 1986 rates. We believe that productivity gains can and should continue. Although ProPAC recommends a 1.5 percent productivity offset, we are proposing a 1.0 percent productivity offset in the FY 1987 policy target adjustment factor. We expect that a two percent or more annual increase in productivity would not be unreasonable; however, consistent with our approach in the September 3, 1985 final rule (50 FR 35707), we believe that a conservative offset (1.0 percent) would not impact hospitals to the same extent as a greater adjustment would.

Average annual growth for productivity in the non-farm business sector during the period 1980 through 1985 was 1.07 percent according to the Bureau of Labor Statistics, Department of Labor. Average annual growth over a longer span of time, 1965 through 1985, was 1.12 percent per annum. Though these two growth rates imply a degree of stability, such is not the case. Year to year changes in productivity are quite volatile (see following table). Data Resources Incorporated (DRI), in their May 1986 forecast model, is predicting a productivity gain of 1.8 percent for 1987. Because these numbers are at variance, and in order to be conservative, we are proposing to set the FY 1987 productivity adjustment offset at one percent.

Output Per Hour of All Persons, Non-Farm Business Section (DRI)

Percentage Growth:	
1975	1.8
1976	2.5
1977	1.6
1978	0.8
1979	−1.6
1980	−0.5
1981	−1.0
1982	−0.6
1983	3.4
1984	1.6
1985	−0.1
1986*	0.0
1987*	1.8

*Forecast.

(3) Cost Effective Technologies. This add-on is a policy target rate of increase to allow for growth in cost-increasing, health-enhancing new technologies and scientific advances.

As with productivity, there is limited historical data to set a prospective target empirically, and there are substantial definitional problems in determining what measures would accurately reflect the intent of the law. Further, acquisition costs for some technologies or scientific advances eventually have cost-decreasing effects.

ProPAC is conducting a number of studies to analyze this factor. Our assessment appears to be consistent with ProPAC evaluations. A major difference is that ProPAC is conducting analyses of the use of individual technologies for potentially making changes to the prospective payment rates. Of particular interest is the ProPAC finding that new medical devices and diagnostic procedure costs may have only a small impact on overall increases in Medicare payments and that major increases in costs during the 1970s were the result of changes in practice patterns (see p. 11 of the Technical Appendixes of ProPAC's April 1, 1986 Report). ProPAC has recommended a much lower target value (0.7 percent) for cost-effective technologies in FY 1987 than the 1.5 to 2.0 percent they recommended last year, although they are also recommending (Recommendation 29) a specific add-on amount for magnetic resonance imaging technology.

Our proposal is to set the policy target adjustment factor for cost-effective technologies and associated labor and nonlabor inputs at 1.0 percent. We have deliberately set this factor at a more generous level than that recommended by ProPAC because we are proposing to incorporate capital-related costs into the prospective payment system. We note that in its report to the Secretary,

ProPAC recommended that the adjustment for scientific and technological advances be increased if capital were added to the prospective payment system, although they did not include a specific increment. Our intention is to encourage hospitals to use health-enhancing new technologies and scientific advances through setting this factor at a level that would promote such usage.

(4) Improvements in Practice Patterns. We are changing the descriptive title of this output measure used in the analytical framework for updating the FY 1986 rates from the "elimination of ineffective practice patterns" to "improvements in practice patterns." However, the essence of this measure remains unchanged. It reflects the relationship between efficacious and cost-effective outputs (services) and discharges. We refer the reader to Appendix B of the June 10, 1985 proposed rule (50 FR 24440) for a more indepth discussion of the framework for analyzing the policy target adjustment factors. Substantial savings result from improving practice patterns through cost effective use of resources. Improvements in practice patterns include shifts in the use of certain inpatient services for hospitalized patients to more appropriate lower cost settings and the elimination of services that do not give value for money expended; that is, reduced outputs associated with improvements in practice patterns.

In the first two years of the prospective payment system, the average length of stay of Medicare beneficiaries in prospective payment system hospitals decreased by 18 percent, despite an increase in case mix.

TABLE: MEDICARE AVERAGE LENGTH OF STAY

FY 1983 Nonwaiver State Short-Stay Hospitals	FY 1985 Prospective Payment Hospitals (days)	Percent Change
9.5 days	7.8	−18

Source: HCFA Medicare Statistical System, Bureau of Data Management and Strategy.

Part of this reduction in length of stay resulted from providing certain care and services, either prior to hospital admission or after discharge, in a lower cost setting or from reductions in ancillary services provided. Prior to implementation of the prospective payment system, similar services had been furnished to beneficiaries as inpatient hospital care. Lower cost settings include outpatient, skilled nursing facilities (SNFs), home health agencies (HHAs), and intermediate care facilities (ICFs).

Both ProPAC data and Medicare data on site substitution for prospective payment system and non-prospective payment system bills show that the percentage of discharges to SNFs, HHAs, and ICFs are higher for prospective payment system patients than non-prospective payment system patients. In light of the differences between the types of hospitals subject to and excluded from the prospective payment system, however, one cannot infer a direct causal link between the type of payment system and the utilization of lower cost settings.

It is difficult to determine the precise level of cost reduction associated with an 18 percent drop in average length of stay. The percentage of cost reduction can vary considerably in individual cases. For example, if prior to hospital admission a beneficiary receives required tests on an outpatient basis and the same laboratory or diagnostic tests were previously provided and billed in the inpatient setting, inpatient costs could be reduced for both ancillary and routine services. If physicians determine that skilled nursing care could be provided in an SNF setting, the level of inpatient cost reduction associated with the reduced hospital stay would differ from the first example. Further, if a hospital improved practice patterns by performing diagnostic or lab tests in the hospital, whereas these services were previously contracted out, there may not be any change in the number of these services furnished and related costs could increase, but improved processing times could lower length of stay and total hospital costs. In this situation, inpatient cost reductions could be relatively lower, comprised mainly of changes in the cost of routine services.

For purposes of determining day outlier cases, we assume the marginal cost of an additional day of care to be equal to 60 percent of the average per diem for the applicable DRG, excluding payment for pass-through costs. ProPAC references studies that indicate that marginal costs associated with a patient day range between 20–80 percent. Assuming an average marginal cost rate of 50 percent, the 18 percent reduction in length of stay in the first two years of the prospective payment system translates into a nine percent reduction in costs. Since two percent were already offset for improved practice patterns in determining the FY 1986 prospective payment system update, a seven percent reduction in costs remains. Considering incentives inherent under prospective payment, together with the intent to be gradual and conservative, we are recommending a two percent offset for improved practice patterns in the FY 1987 policy target adjustment factor.

ProPAC's recommendation for this factor is a 0.6 percent offset. With respect to the 1.4 percent difference (between ProPAC's recommendation and our proposal) in the amount of the offset for this particular portion of the policy target adjustment factor, we point out that ProPAC's accounting for the effects of changes in site of substitution is less inclusive than a measure reflecting overall improvements in hospital practice patterns. Just as there are definitional differences between ProPAC and us regarding what is included in the factor "hospital productivity targets", improvements in hospital practice patterns reflect not only shifts in the furnishing of inpatient services to alternative settings, but also the elimination of unnecessary or cost ineffective services. When the combined effects of our productivity and ineffective practices patterns offsets (−3.0 percent, exclusive of cost-effective technologies) are compared to ProPAC's discretionary adjustment factors for productivity and site-of-care substitution (−2.1 percent), we believe that we are not so dissimilar from ProPAC.

(5) Proposed Composite Policy Target Adjustment Factor. For FY 1987, we propose to adjust the average standardized amounts by a percentage composite policy target adjustment factor, as authorized under section 1886(e)(4) of the Act. For FY 1987, this composite policy target adjustment factor is a composite of the offsets and add-ons for productivity, cost-effective technologies, and improvements in practice patterns, as follows:

	Percent
Productivity	−1.0
Cost-effective technologies	+1.0
Improved practice patterns	−2.0
Total	−2.0

(6) Other ProPAC Recommendations on the Policy Target Adjustment Factors. ProPAC recommends (Recommendation 3) that an allowance should be made in the overall update factor to reflect real changes in case mix that are due to changes associated with the characteristics of patients. The allowance should reflect both shifts in patients among the DRG categories, as measured by changes in the average case-mix index (DRG case-mix change), and changes in the mix of patients within DRG categories (patient complexity change). ProPAC

recommends an allowance in the FY 1987 Federal rates of 0.9 percent, representing a 0.2 percent adjustment for DRG case-mix change and a 0.7 percent adjustment for patient complexity change.

This recommendation was previously reflected in ProPAC's recommendations No. 1 and No. 11 issued April 1, 1985. (See the June 10, 1985 proposed rule (50 FR 24446).) We agree, in principle, that the prospective payment rules should reflect real increases in case-mix.

ProPAC also recommends that the DRG weights should be adjusted to remove any increase in reported case mix during FY 1986. This would include nominal increases net of real increases.

Of the 0.9 percent add-on for real case mix that ProPAC recommends, 0.7 percent is for "patient complexity," which ProPAC defines as changes in the mix of patients within DRGs. We do not recognize changes in the mix of patients *within* DRGs (that is, severity of illness), because we do not believe there is currently any satisfactory method for measuring such severity.

ProPAC based its recommendation on a study being conducted by the Commission on Professional and Hospital Activities (CPHA). This study uses medical record discharge abstract data on Medicare and non-Medicare discharges from 1980–1984. Based on a complexity score for each discharge, the study results indicate significant increases in length of stay associated with greater complexity for both Medicare and non-Medicare patient populations during the period 1982–1983. However, the increase was substantially greater for the Medicare patients. (See *Technical Appendices* to the April 1, 1986 ProPAC Report, p. 22.)

We do not believe, based on the information provided by ProPAC, that we should accept at this time the results of the CPHA study. We note, for example, that the data are based on a self-selected sample of hospitals. We believe that any study dealing with as sensitive an issue as patient severity should be based on a more objectively established data base than a self-selected sample. Also, as stated in the report, "The Commission has assumed that the increase (in length of stay) during the period 1982–1984 was highly subject to the influence of improved hospital coding practices and may not represent actual changes in complexity. Thus, the Commission has chosen to base its estimate of real complexity change on the experience of hospitals prior to 1983." We do not believe it is proper to increase the prospective payment rates for FY 1987 based on conclusions about patient complexity prior to the implementation of the prospective payment system. It is widely acknowledged that the prospective payment system created new incentives for hospitals and we believe it would be appropriate for any severity adjustment or other adjustment purporting to represent increases in patient severity within DRGs to be based on prospective payment system data.

ProPAC also states that "The Commission has also assumed that a 0.7 percent increase in length of stay associated with increased complexity would translate into a 0.7 percent increase in costs." We question the basis for this statement in that it presumes that increases in cost per case are perfectly proportional to increases in length of stay due to increased complexity. There is no reason to assume *a priori* that there is a one-to-one relationship between cost increases and increases in length of stay. To the contrary there is considerable evidence that the marginal cost of care on a per diem basis is generally well below 1.0. We believe these kinds of DRG patient complexity adjustments should await the development of specific methodologies especially designed to measure them.

Preliminary HCFA estimates indicate that case mix has increased by 2.7 percent in FY 1986. Using ProPAC's estimate of a 0.9 percent add-on for real case mix, the net case-mix change adjustment would be −1.8 percent. However, as discussed above, only 0.2 percent of ProPAC's add-on is for real case mix. Our preliminary estimate is that real case mix has increased 0.6 percent. This estimate is based on long term trend estimates of real case mix increases of 0.4 percent and an additional adjustment of 0.2 percent for further shifts of DRG 39 (lens procedures with or without vitrectomy) cases to outpatient settings. Thus, our proposed adjustment for net case-mix change is −2.1 percent, that is, −2.7 percent for total case-mix change plus 0.6 percent for real case-mix increases. These estimates for both total case-mix and real case-mix changes are to be updated in the final rule based on additional FY 1986 data that is expected to be available subsequent to the publication of this proposed rule.

ProPAC recommends (Recommendation 13) that the standardized amounts be recalculated using cost data that reflect hospital behavior under the prospective payment system. The results of such a recalculation, with appropriate modifications, could be used in determining the update factor or in rebasing the standardized amounts.

The initial standardized amounts were established by using data from 1981 cost reports for each geographic class of hospitals and updating that data to FY 1984 by an inflation adjustment. Section 1886(d)(3)(A) of the Act specifically provides that the average standardized amounts for any given year beginning with FY 1985 are to equal the respective standardized amounts for the previous year, adjusted by an update factor. We believe, therefore, that it would be inappropriate to recalculate (or rebase) the standardized amounts by repeating the original process with later data, such as cost data accumulated under the prospective payment system.

We also believe that it would be inappropriate to calculate the update factor using cost data under the prospective payment system. Under the law, the increased costs of the market basket of hospital inputs, plus a factor for increased costs of items not otherwise specifically identified, rather than actual hospital costs, are the baseline for annual adjustments. In other words, this provision implies that Congress envisioned the annual update being related to the change in the market basket even if, as in the period prior to implementation of the prospective payment system, actual hospital costs rose more rapidly. This limitation is also reflected in the methodology specified in the statute for deriving the FY 1984 rates based on 1981 cost data. That is, section 1886(d)(2)(B) of the Act allowed updating to FY 1983 by the full amount of estimated hospital cost inflation, but allowed updating from FY 1983 to FY 1984 only by the market basket plus one percentage point.

In short, the statute clearly did not intend that actual costs be routinely considered in setting future prospective payment rates to the extent that those costs increased faster than the market basket index plus adjustments to reflect costs not otherwise specifically identified. Efforts to mechanically adjust the payments rates to reflect current costs could frustrate the statutory intent of restricting inflation in the payments to approximately the market basket inflation rate. (In this regard, we note that section 9101 of Pub. L. 99–272 amended section 1886(b)(3)(B) of the Act to require that the update factor not exceed the market basket.)

The foregoing discussion does not imply a prohibition on considering actual hospital cost experience as one factor in the determination of the yearly prospective payment update factor. To the contrary, the various statutory criteria to be considered by ProPAC in recommending the update factor clearly

center on certain aspects of the costs being incurred by hospitals. Section 1886(e)(2) of the Act requires ProPAC to consider "hospital productivity, technological and scientific advances, the quality of health care provided in hospitals . . ., and long-term cost-effectiveness in the provision of inpatient hospital services." These considerations are intended to identify valid reasons why payments should rise more or less than the market basket increase and necessarily involve assessments about the costs actually being incurred by hospitals. Similarly, the Secretary, in determining the update factor, is required by section 1886(e)(4) of the Act to "take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality," a formulation that authorizes the consideration of costs incurred under the prospective payment system.

In summary, we believe that the 1981 cost data met the statutory requirement that we use the best data available to establish the initial prospective payment rates. Subsequently, the FY 1984 rates are to be adjusted each year by taking into account those factors (such as productivity and technology) stated in section 1886(e)(2) of the Act. We do not believe it is appropriate to engage in a wholesale recalculation of the rates based on later data, update factors, or adjustments that are tied exclusively to later cost data.

g. Summary. The combined effect of the forecasted increase in the hospital market basket, the proposed correction for the forecast market basket error for FY 1986, the proposed correction of case-mix change for FY 1986, and the proposed composite policy target adjustment factor would be as follows:

	Percent
Forecasted market basket increase	+3.6
Forecasted market basket error for FY 1986	−0.4
Correction for case-mix change for FY 1986	−2.1
Composite policy target adjustment factor	−2.0
Total	−0.9

Such a negative update factor would result in a modest decrease in the standardized amounts for FY 1987, compared to those for FY 1986, and a corresponding reduction of anticipated revenue for hospitals subject to the prospective payment system. However, although we have substantial technical and legal justification for issuing FY 1987 standardized amounts that would be lower, on average, than FY 1986 standardized amounts (similar to the justification for a 4.42 percent decrease in the FY 1986 standardized amounts), we do not propose to do so. In addition, because we believe it is important to protect the prospectivity of this payment system, we do not plan to recoup any excessive payments resulting from the overstated FY 1986 standardized amounts.

The prospective payment system was intended, from its inception, to produce significant changes in the hospital industry. However, we do not want to cause these changes to take place too rapidly, because that may result in disruptions and unintended consequences that would adversely affect the industry, its patients, and us. Neither do we want to encourage changes that would comprise the access to quality inpatient hospital care historically enjoyed by Medicare beneficiaries. Our objective is to set the FY 1987 update factor at a percentage level that takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, in accordance with section 1886(e)(4) of the Act, and we believe that the payment rates should be set no lower than we have proposed in order to assure that this statutory standard is met.

We believe that in an ideal course of events, the FY 1986 amounts would have been set at a lower level, and the FY 1987 amounts would be increased appropriately. However, the implementation of a new system seldom follows an ideal course. Moreover, we recognize that actually decreasing the standardized amounts would have adverse effects, not only relative to the expectations of affected hospitals, but on the development and acceptance of the prospective payment system. We also recognize that a large portion of the overstatement of the FY 1986 standardized amounts is not attributable to the actions or behavior of the hospital industry. The overstatement is to some extent the result of our desire, shared by Congress, to proceed cautiously with the implementation of the new system. Therefore, it would be inappropriate to set the FY 1987 Federal rates at a level that would appear to be punitive of the hospital industry.

We believe the situation at this point is similar to the situation we faced last year at this time, when our analysis also indicated a decrease in the rates would be appropriate. In view of that analysis, we proposed that the FY 1986 prospective payment rates not be increased above the level of the FY 1985 rates. After consideration of all public comments, we determined that no increase was warranted, and promulgated this decision in the September 3, 1985 final rule. Subsequently, Congress precluded implementation of our FY 1986 changes to the prospective payment system through a series of legislative postponements, and required that all hospitals would continue to receive prospective payments through April 30, 1986 that were computed on the same basis as the payments on September 30, 1985. Effective May 1, 1986, section 9101 of Pub. L. 99-272 provided that hospitals would receive 0.5 percent increase in the Federal prospective payment rates for the remainder of Federal FY 1986, and would receive a 0.5 percent increase in the hospital-specific rates after the first seven months of each hospital's cost reporting period. Hospitals that are excluded from the prospective payment system received an increase of 5/24 percent in their target rates of increase for their cost reporting periods which began on or after October 1, 1985 (which is equivalent to an increase of 0.5 percent for the last 5 months of their 12-month cost reporting periods). The 0.5 percent increase selected by Congress under circumstances in which a decrease was technically warranted is the same increase that we are now proposing under similar circumstances.

While we have a responsibility to protect the integrity of the Medicare trust funds, we realize that to decrease the prospective payment rates while at the same time proposing major reforms in the prospective payment system (for example, our proposal to bring capital costs under a prospective payment system), could lead to concern that we would be economically disadvantaging hospitals. Therefore, we believe that it is in the best interest of all parties, that is, the public, the hospital industry, and the government, to propose an increase in the rates for FY 1987.

Accordingly, we are proposing that the Federal rates be increased by 0.5 percent for discharges occurring on or after October 1, 1986, and that the hospital-specific rates be increased by 0.5 percent for cost reporting periods beginning on or after October 1, 1986. In addition, the target rates of increase for hospitals excluded from the prospective payment system would also be increased 0.5 percent for cost reporting periods beginning on or after October 1, 1986.

For the reasons given above, we believe that the resulting payments would take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. However, we wish to emphasize that our proposal of this increase does not lessen our confidence in the analysis which shows

that a decrease in the rates would be appropriate.

Because we are proposing to restandardize the base-year costs for changes to the wage index, indirect medical education costs, and disproportionate share hospital adjustments, in addition to using the revised market basket weights for determining the labor-related and nonlabor-related shares of the standardized amounts, the FY 1987 standardized amounts would be different from a 0.5 percent increase over the FY 1986 standardized amounts as published in the May 6, 1986 interim final rule (51 FR 16778). In addition, we note that further adjustments would be made to the standardized amounts for Pub. L. 99–272 provisions regarding the payment equality adjustment for indirect medical education costs, and the special adjustment for teaching hospitals under section 9202(j) of Pub. L. 99–272.

The table below compares our position with that of ProPAC with respect to the update factor. Please note that this table, unlike the table included in the September 3, 1985 final rule (50 FR 35696), contains a third column, "Adjusted ProPAC." In this column, our technical staff have revised, where appropriate, ProPAC's components of the update factor using more recent data then were available to ProPAC at the time it developed its recommended update factor. We want to emphasize that we are providing the adjusted ProPAC figures merely for purposes of comparison, and that these figures represent our techical staff analysis rather than ProPAC's views as to how those figures will be adjusted.

For the benefit of the reader, we are providing, below, a comparison table of HCFA's proposed update factor and ProPAC's recommendation.

COMPARISON OF THE HCFA AND PROPAC UPDATE FACTORS

	HCFA	ProPAC	Adjusted ProPAC
Market Basket [1]	3.6	4.6	3.6
Correction for Forecast Error for FY 1986	−0.4	[2] −0.3	[2] −0.6
Policy Target Adjustment Factor:			
Productivity	−1.0	[3] −1.5	[3] −1.5
Science and Technology	1.0	[4] 0.7	[4] 0.7
Practice Pattern	−2.0	[5] −0.6	[5] −0.6
Total	−2.0	−1.4	−1.4
Case-Mix Change for FY 1986:			
Total [6]	−2.7	−1.0	−2.7
Real [7]	0.6	0.9	0.9
Net Case Mix Change	−2.1	−0.1	−1.8
Update Total	−0.9	+2.8	−0.2

[1] This is an estimate of change in the rebased market basket and includes capital.

[2] The forecast error correction is based on changes in the current market basket due to the underestimate of wage and salary increases by Data Resources Inc. (DRI), and the downward effect on the DRI forecast estimates due to the introduction of the Gross National Product (GNP) revisions. ProPAC recommends adjusting only for external price proxies that is, the total less wages. The recommended HCFA adjustment is for all forecast errors.

[3] Discretionary Adjustment Factor, ProPAC's variation of the Policy Target Adjustment Factor.

[4] If capital is added to the standardized amounts in FY 1987 at a level lower than projected under current law, Pro PAC recommends that this component be increased in addition to providing for a separate add-on for magnetic reasonance imaging scans.

[5] ProPAC measures site substitution here and includes observed productivity changes in their Productivity offset.

[6] This is preliminary estimate by HCFA based on billing data, and is subject to revision. A peliminary ProPAC estimate, based on historical trends, indicates a 1.0 percent increase which they note is subject to change with newer data, and which we believe to be too low. Included in ProPAC's total is an estimate of real case-mix of 0.2 percent.

[7] This estimate includes long term trend estimates of real case mix of 0.4 percent and an adjustment of 0.2 percent for further shifts of DRG 39 to outpatient settings.

For the benefit of the reader. we are displaying actual and projected increases in payment per admission under the prospective payment system.

RATE OF INCREASE IN PER CASE PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM

Fiscal year	National average total payment (per case) [1]	Annual rate of increase (percent) [2]	Cumulative rate of increase (percent) [3]
1983 [2]	$3,168		
1984	3,485	10.0	10.0
1985	3,870	11.1	22.2
1986	4,134	6.8	30.5
1987	4,298	4.0	35.7

[1] These numbers represent total payment per admission, inclusive of payments for capital-related costs and other pass-throughs, assuming the adoption of this proposed rule.

[2] The prospective payment system was implemented at the beginning of FY 1984.

[3] These percentages are rounded to the nearest one-tenth of one percent.

4. Other Adjustments to the Average Standardized Amounts

a. Part B Costs. Section 1862(a)(14) of the Act prohibits payments for nonphysician services furnished to hospital inpatients unless the services are furnished either directly by the hospital, or by an entity under arrangements made by the hospital under which Medicare's payment to the hospital discharges the beneficiary's liability to pay for the services furnished.

In the September 3, 1985 final rule, we increased the average standardized amounts by 0.13 percent so that they represent costs previously billed under Part B (50 FR 35708). We are proposing to make no further adjustments for this factor in FY 1987, or in the future, because the appropriate adjustment has been built into the FY 1986 base.

b. FICA Taxes. Section 1886(b)(6) of the Act requires that adjustments be made in the base period costs in recognition that certain hospitals were required to enter the Social Security system and begin paying FICA taxes as of January 1, 1984. In the September 3, 1985 final rule, we increased the average standardized amounts by 0.18 percent to account for additional costs of payroll taxes for hospitals entering the Social Security system (50 FR 35708). We are proposing to make no further adjustments for this factor in FY 1986, or in the future, because the appropriate adjustment has also been built into FY 1986 base.

c. Nonphysician Anesthetist Costs. Section 1886(d)(5)(D) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98–369, this pass-through is effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987. In the September 3, 1985 final rule, we noted that the FY 1986 average standardized amounts automatically included the appropriate adjustment (0.5 percent) (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1986 base, we are not proposing to make further adjustments to the average standardized amounts for FY 1987.

d. *Indirect Medical Education.* Section 9104 (b) of Pub. L. 99–272 added section 1886(d)(3)(C)(ii) to the Act to provide that, effective for discharges occurring on or after October 1, 1986, the average standardized amounts be further reduced, taking into consideration the effects of the standardization for indirect medical education costs as described in section II.A.1.c. of this addendum. Specifically, for each geographic area (regional and national, urban and rural), total payments including indirect medical education and disproportionate share hospital adjustments, based on payment rates standardized for an 8.1 percent curvilinear indirect medical education factor and disproportionate share, shall be neither more nor less than the estimated total of payments, including indirect medical education adjustment payments that would have been made based on rates standardized for an 11.59 percent linear indirect medical education factor and paid out at 8.7 percent on a curvilinear basis. The adjustment is accomplished on a regional basis in order to reflect Congressional intent that the necessary

calculations will not redistribute payments among the regions.

Through this adjustment, Congress is ensuring that total prospective payments, on a regional basis, taking into consideration the restandardization of rates for disproportionate share payments and for a revised indirect medical education payment factor of approximately 8.1 percent on a curvilinear basis, will equal payments that would have resulted with rates standardized for an 11.59 percent indirect medical education adjustment factor, and payments computed using an indirect medical education factor of 8.7 percent applied on a curvilinear basis. For discharges on or after October 1, 1988 (that is, after that part of the law requiring disproportionate share payments sunsets), the adjustment must be such as to ensure that the system savings resulting from the changes to the indirect medical education factor are preserved.

We recognize that the statute discusses that adjustment in terms of a "reduction" in the average standardized amounts. However, we note that, as stated in sections 1886(d)(2)(C)(ii)(I) and (II), the purpose of this "reduction" is to attain equality of payments. As can be seen from the table below, attaining such equality in certain regions requires a slight increase in the rates. This result, along with the discussion in the Conference Committee Report that stresses the equality of payments, supports our interpretation that the standardized amounts are not to be reduced except where necessary to attain payment equality.

Therefore, under section 1886(d)(3)(C)(ii) of the Act, for FY 1987 we are proposing to adjust the urban and rural regional and national standardized amounts (including the capital amounts) to account for indirect medical education payments. It should be noted that these factors have been applied to both the Federal operating standardized amounts (excluding capital) and the Federal capital-related standardized amounts. The reason for this is that section 1886(d)(2)(C)(ii) requires an adjustment to "each of the average standardized amounts. . . so as to provide for a reduction in the total of the payments. . . ." Since as described elsewhere in this document, eligible hospitals will be able to receive additional payments for the indirect costs of medical education and as disproportionate share hospitals, adjustments must be made to the capital rates in order to maintain the payment equality required in the law.

The indirect medical education payment equality factors are as follows:

Region	Urban		Rural	
	Operating Costs Excluding Capital	Capital-Related Costs	Operating Costs Excluding Capital	Capital-Related Costs
1. New England (CT, ME, MA, NH, RI, VT)	.98055	.98108	.96662	.99667
2. Middle Atlantic (PA, NJ, NY)	1.00728	.99154	1.03574	.99561
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	.98090	.99880	.97586	1.00106
4. East Nort Central (IL, IN, MI, OH, WI)	.99833	.99945	.99027	.99905
5. East South Central (AL, KY, MS, TN)	.99143	.99192	1.00343	1.00249
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	1.01842	.99505	.99909	.99918
7. West South Central (AR, LA, OK, TX)	1.00101	.99774	.99568	.99996
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.04658	1.00035	1.02251	.99997
9. Pacific (AK, CA, HI, OR, WA)	1.01121	.99785	1.01237	1.00079
10. National	.99684	.99707	.99989	.99986

e. Special Treatment of States Formerly Under a Waiver From Medicare's Hospital Reimbursement System. Section 9202(j) of Pub. L. 99–272 provides for special treatment of States formerly under a waiver. The provision provides for special treatment of hospitals in a State whose waiver under section 1886(c) of the Act has been terminated effective with cost reporting periods beginning on or after January 1, 1986, in which—

- The hospital shall be permitted to change the method by which it allocates administrative and general costs to the direct medical education cost centers to the method specified in the Medicare cost report;
- The hospital's hospital-specific portion of the prospective payment rate shall be adjusted for any hospital that actually chooses to use the Medicare cost report; and
- The regional adjusted DRG prospective payment rate in the region the State is located may be appropriately adjusted based on the assumption that all teaching hospitals in the State use the Medicare cost report. All such adjustments are to be based on the best data available.

Of the States for which hospitals were reimbursed under a waiver, Massachusetts and New York have terminated their waivers. However, hospitals in those States had been reimbursed for services pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972. Under current existing waivers, Maryland hospitals are paid for services pursuant to a reimbursement system under section 1814(b) of the Act and New Jersey hospitals are paid for services pursuant to a reimbursement system under section 1886(c) of the Act.

Even though section 9202(j) of Pub. L. 99–272 cites waivers under section 1886(c) of the Act, the conference committee report does not express any such restriction. The conference committee report (H.R. Rep. No. 453, 99th Cong., 1st sess. 486 (1985)) expressing the committee's expectation states,

"Certain hospital reimbursement systems that received waivers from Medicare have used methods of allocating administrative and general costs that are different from those required by the Medicare hospital cost reporting forms. The conferees are concerned that, where these alternative allocation methods are in use, the base year direct GME costs used to determine the approved FTE resident amounts established by other provisions of this legislation, may be understated.

The conferees direct the Secretary to permit changes in these alternative allocation methods. The conferees further direct the Secretary to adjust the regional standardized payment amounts and the hospital-specific amounts to account for the overstatement of these amounts due to the method of allocation of overhead used by teaching hospitals in the base period."

In order to meet the expectations of the committee, we believe we should treat hospitals in States under a previous waiver that were not paid pursuant to section 1886(c) of the Act in accordance with such expectations. However, since there is no authority to treat hospitals in States formerly under waivers other than section 1886(c) waivers under the provisions of section 9202(j) of Pub. L. 99–272, we believe the expectations of the conference committee may be carried out under the general exception and adjustment authority under section 1886(d)(5)(C)(iii) of the Act.

Of the two States which terminated their waiver, New York is the only State affected by this provision. Most hospitals in New York, including hospitals with direct medical education cost centers, allocate administrative and general costs in a manner which differs from the recommended order prescribed in the Medicare cost report. Many of these hospitals use an order of allocation in which the administrative and general cost center *follows*, rather

than precedes the direct medical education cost centers. As a result of this methodology, none of the hospital's administrative and general costs were allocated to the direct medical education cost centers. This had the effect of increasing the Medicare inpatient operating costs for teaching hospitals in New York and reducing the amount of medical education costs. The results are the same as the expressed concerns of the conference committee as stated above.

Under the authority of section 1886(d)(5)(C)(ii), we propose to implement the expectations of the conference committee for teaching hospitals in New York. Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in New York with direct medical education cost centers will be permitted to change the method by which they allocate administrative and general costs to the method specified in the Medicare cost report. Also, the hospital-specific portion of the prospective payment rate will be adjusted for any such hospital that chooses to use the Medicare cost report effective with cost reporting periods beginning on or after January 1, 1986.

With respect to adjusting the regional standardized payment amounts, the Middle Atlantic census division will be affected by such an adjustment. The Middle Atlantic census division consists of the States of New York, New Jersey, and Pennsylvania, and these States would be affected by any change. We believe that it is important for the effectiveness of the prospective payment system to ensure that payment rates are actually prospective in their effect and based on the best data available. For purposes of this proposed rule, we are estimating the impact on the regional standardized payment amounts using cost reports from a sample of New York hospitals with direct medical education cost centers. The adjusted regional standardized payment amounts would be effective for discharges occurring on or after October 1, 1986.

In adjusting the regional standardized payment amounts for the Middle Atlantic census division, a sample of FY 1982 (base year for determining hospital-specific rate) cost reports from New York hospitals with direct medical education cost centers were recalculated to change the method by which administrative and general costs were allocated to the method specified in the Medicare cost report. The allowable Medicare inpatient operating costs from the revised Medicare cost reports for each sample hospital were used in estimating a revised hospital-specific rate. The revised hospital-specific rate was compared to the hospital-specific rate derived from the original method by which administrative and general costs were allocated. A percentage change in the hospital-specific rates was developed for each sample hospital. The percentage change was then applied to the base year cost data, representing allowable costs per Medicare discharge, for each sample hospital included in the data base used to construct the standardized amounts. The average percentage change for the sample hospitals was applied for each of the remaining New York hospitals with direct medical education cost centers that were not included in the sample. After the costs per case of the New York teaching hospitals were thus adjusted, the regional standardized payment amounts were recomputed in accordance with the past methodologies used to calculate such rates. For the final rule, the regional standardized payment amounts will be recalculated showing the full effect of the actual change for all hospitals in New York with direct medical education cost centers.

f. Outliers. Section 1886(d)(5)(A) of the Act requires that, in addition to the basic prospective payment rates, payments must be made for discharges involving day outliers and may be made for cost outliers. Section 1886(d)(2)(E) of the Act correspondingly requires that the standardized amounts be reduced by a proportion that is estimated to reflect outlier payments. Furthermore, section 1886(d)(5)(A)(iv) of the Act further directs that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made based on the prospective payment rates in any year. In FY 1984 we estimated outlier payments as six percent of total payments (including both standard prospective payment system payments and outlier payments). We made the maximum estimate permitted under the law in order to ensure that we would provide an adequate margin for outlier payments.

For both FY 1985 and FY 1986, we reduced the size of the reserve for outliers from six percent of total payments to five percent of total payments in order to provide proportionately greater payment for typical cases and avoiding any great risk of general disadvantage to hospitals. We believe that it was in the greater interest of hospitals and the Medicare program to eliminate some of the reserve for outliers and correspondingly increase the amount in the standardized amounts, thereby providing hospitals with somewhat larger Federal rates for typical cases. We note that this has had the effect of increasing the predictability of total payments for hospitals in that less of the total is attributable to those cases that meet particular qualifications. Therefore, we propose to continue to set the size of the outlier reserve at approximately the five percent level for FY 1987. As indicated in the previous rules on prospective payment, we will pay for any outlier that meets the criteria in § 412.80, even if actual aggregate outlier payments result in more than five percent (as proposed) of total payments.

We are not proposing to revise the day outlier and cost outlier thresholds. For FY 1986, we set the day outlier threshold at the lesser of 17 days or 1.94 standard deviations. We refer the reader to Table 5 in this addendum for the FY 1986 and proposed FY 1987 DRG day outlier thresholds. For FY 1986, we set the cost outlier thresholds at the greater of two times the Federal rate for the DRG, or $13,500. We are proposing to retain these thresholds for FY 1987.

Because of the extent of the changes proposed in this rule, we are providing four examples below (two for day outliers and two for cost outliers). The first day outlier example and the first cost outlier example are applicable to hospitals with cost reporting periods that occur on the same basis as the Federal fiscal year (that is, October 1, 1986). The other examples would apply to hospitals with cost reporting periods that occur on a different basis than October 1, 1986. The prior outlier examples in the September 1, 1983 interim final rule (48 FR 39777) did not show the full computation of the indirect medical education factor (or, of course, the recent changes to that factor) and did not include disproportionate share hospital adjustments and the capital-related standardized amounts.

The following is an example of how the additional payment would be determined for a day outlier in FY 1987:

Hospital X is a small central city teaching hospital located in the San Francisco MSA. Hospital X has a ratio of interns and residents to beds of .1 and is eligible for a disproportionate share adjustment factor of 5 percent. Mrs. Smith is admitted to hospital X on October 3, 1986 and is discharged October 31, 1986. Mrs. Smith's stay is classified in DRG 31. Because Mrs. Smith's 28 day stay exceeds the 20 day length-of-stay outlier threshold for DRG 31, hospital X is eligible for payment for 8 outlier days in addition to the

otherwise applicable prospective payment. The amount of hospital X's outlier payment (excluding the usual Federal payment that applies for both outlier and non-outlier cases) is calculated as follows:

Step 1.—Computation of Federal rate (excludes payments for capital, indirect medical education costs and disproportionate share hospital adjustment)

Pacific Census Division Urban Standardized Amounts:
- Labor-related $2083.58
- Non labor-related ..... $ 884.05

National Urban Standardized Amounts:
- Labor-related $2194.80
- Non labor-related ..... $ 788.96

San Francisco MSA Wage Index 1.6395
DRG 31 Relative Weight ..... .5383

Federal rate
=.5383 [.50 ($2083.58×1.6395+$884.05)+.50 ($2194.80×1.6395+$788.96)]
=.5383 ($2150.04+$2193.67)
=$2338.22
Federal portion of prospective payment rate =75 percent
Federal payment (excluding capital) =.75 ($2338.22)=$1753.67

Step 2.—Computation of Federal Capital Payment

Pacific Census Division Urban Standardized Capital Rate $274.86
National Urban Standardized Capital Rate $240.71
Federal Portion of Capital Prospective Payment Rate (percent) 20
DRG 31 Relative Weight ..... .5383

DRG 31 Federal Capital Payment Rate (reflects regional/national blends)
[.50($274.86+.50($240.71)](.5383)=$138.77
DRG 31 Federal Capital Payment
=$138.77×.20=$27.75
Federal Prospective Payment, including capital =$1753.67+$27.75=$1781.42

Step 3.—Computation of Day Outlier Payments

Outlier days 28−20=8
DRG 31 geometric mean length of stay 3.9 days
Marginal cost factor .60
Outlier payment (excludes disproportionate share hospital and indirect medical education costs) = Number of outlier days × (Total Federal prospective payment ÷ Geometric mean length of stay for DRG) × Marginal cost factor
=8($1781.42÷3.9).60=$2192.52

Step 4.—Computation of Indirect Medical Education Adjustment for Day Outliers

Intern and Resident/Bed Ratio
Indirect medical education adjustment factor 2[1+.1).405−1]=.7871 or 7.871%
Indirect medical education outlier payment=Indirect medical education adjustment factor × Outlier payment=.07871($2192.52)=$172.57

Step 5.—Computation of Disproportionate Share Payment for Day Outliers

Disproportionate share adjustment factor 5% or .05
Disproportionate share hospital outlier payment=Disporortionate share hospital adjustment factor×Outlier payment=.05($2192.52)=$109.63

Step 6.—Total Day Outlier Payments

Regular	$2,192.52
Indirect medical education	172.57
Disproportionate share hospital	109.63
Total	2,474.72

The following is an example of how the additional payment would be determined for a high cost outlier in FY 1987:

Same facts as in the day outlier example with the exception that Mrs. Smith's length of stay was 16 days and she incurred total billed charges of $100,000.

Step 1.—Computation of Hospital X's Standardized Cost

[Includes captial]

Billed Charges—$100,000.00
National ratio of cost to charges[1]—.71
Indirect medical education adjustment factor—.07871
Disproportionate share hospital adjustment factor: Hospital X's Standardized Cost=$100,000.00 ÷1+(.07871+.05)×.71=$62,903.67

Step 2.—Determination of Cost Outlier Thresholds

Computation 1 (Based on Federal Rate)

DRG 31 Federal rate, excluding capital—$2338.22
DRG 31 Federal Capital Payment Rate—[.50($274.86)+.50($240.71)](.5383)=$138.77
Federal rate, including capital, for threshold computation—$2338.22+$138.77=$2476.99
Federal rate, doubled—2×$2476.99=$4953.98

Computation 2 (Based on Wage Index Adjusted Standard Cost Outlier threshold)

Standard Cost Outlier Threshold—$13.500
Labor-related share [1] 69.24%
Nonlabor-related share, excluding capital [1]—23.03%
Nonlabor-related share, capital only [1]—7.73%
Wage index adjusted cost outlier threshold, including capital
($13,500×.6924×1.6395)+($13.500×.2303)+($13.500×.0773)=$19.477.66
Computation 1 result—$4,953.98
Computation 2 result—$19,477.66
Higher or computation 1 or computation 2—$19.477.66
Applicable cost outlier threshold—$19,477.66

Step 3.—Calculation of Cost Outlier Payment

Outlier cost—
$62,903.67−$19,477.66=$43,426.01
Capital portion [1] of hospital cost from market basket—7.73%=.0773
Capital portion of outlier cost—
$43,426.01×.0773=$3,356.83
Federal portion of capital rate—20%
Federal capital portion of outlier cost—
.20×$3,356.83=$671.37
Outlier cost, excluding capital]—
$43,426.01−$3,356.83=$40,069.18
Federal portion of prospective payment rate, excluding capital—75%
Federal portion of outlier cost, excluding capital—.75×$40,069.18=$30,051.89
Marginal cost factor—.60
Outlier payment, capital and non-capital portions—
($671.37−$30.051.89).60=$18,433.96

Step 4.—Cost outlier payment for indirect medical education costs

Interns and resident/Bed ratio—.1
Percentage add-on for indirect medical education—7.871%
Indirect medical education cost outlier payment—$18,433.96×.07871=$1.450.94

Step 5.—Cost outlier payment adjusted for Disproportionate Share Hospital

Disproportionate share hospital percentage add-on—5%
Disproportionate share hospital outlier payment—$18,433.96×.05=$921.70

Step 6.—Total cost outlier payements

Regular	$18,433.96
Indirect Medical Education	1,450.94
Disproportionate Share Hospital	921.70
Total	20,806.60

The following is an example of how the additional payment would be determined for a day outlier in FY 1987 for hospitals whose cost reporting period begins *after* October 1, 1986:

The same facts are applicable as in the period day outlier example but with the exception that Hospital X's cost reporting period begins January 1, 1987 and ends December 31, 1987. For discharges occurring between October 1, 1986 and December 31, 1986, Hospital X's prospective payments do not include capital (capital costs for Hospital X would continue to be paid on a pass-

[1] Previously this factor was .72 (see the September 1, 1983 interim final rule (48 FR 39777)) and was derived from 1981 data. The proposed revised factor of .71 reflects the inclusion capital costs, and the exclusion of interest income on funded depreciation and was developed from FY 1984 cost and charge data.

through basis until January 1, 1987). Therefore, for the period October 1, 1986 through December 31, 1986, the amount of Hospital X's day outlier payment is calculated as follows:

Step 1.—Computation of Federal rate (excludes payments for indirect medical education costs and disproportionate share hospital adjustment)

Pacific Census Division Urban Standardized Amounts:
- Labor-related $2083.58
- Nonlabor-related $884.05

National Urban Standardized Amounts:
- Labor-related $2194.80
- Nonlabor-related $788.96

San Francisco MSA Wage Index 1.6395
DRG 31 Relative Weight ..... .5383

Federal rate
=.5383 [.50 ($2083.58×1.6395+$884.05)+.50 ($2194.80×1.6395+$788.96)]
=.5383 ($2150.04+$2193.67)
=$2338.22

Federal portion of prospective payment rate=75 percent
Federal payment=.75 ($2338.22)=$1753.67

Step 2.—Computation of Day Outlier Payments

Outlier days—28−20=8
DRG 31 geometric mean length of stay—3.9 days
Marginal cost factor—.60
Outlier payment (excludes disproportionate share hospital and indirect medical education costs)=Number of outlier days×(Total Federal prospective payment÷Geometric mean length of stay for DRG)×Marginal cost factor=8($1753.67÷3.9).60=$2158.36

Step 3.—Computation of Indirect Medical Education Adjustment for Day Outliers

Intern and Resident/Bed Ratio—.1
Indirect medical education adjustment factor—$2[(1+.1)^{.405}-1]$=.07871 or 7.871%
Indirect medical education outlier payment=Indirect medical education adjustment factor×Outlier payment=.07871($2158.36)=$169.88

Step 4.—Computation of Disproportionate Share Payment for Day Outliers

Disproportionate share adjustment factor 5% or .05

Disproportionate share hospital outlier payment=Disproportionate share hospital adjustment factor×Outlier Payment=.05 ($2158.36)=$107.92

Step 5.—Total Day Outlier Payments

Regular	$2,158.36
Indirect medical education	169.88
Disproportionate share hospital	107.92
Total	2,436.16

The following is an example of how the additional payment would be determined for a cost outlier in FY 1987 for a hospital whose cost reporting period begins *after* October 1, 1986:

The same facts are applicable as in the previous cost outlier example but with the exception that Hospital X's cost reporting period begins January 1, 1987 and ends December 31, 1987. For discharges occurring between October 1, 1986 and December 31, 1986, Hospital X's prospective payments would not include capital (Hospital X's capital costs would continue to be paid on a pass-through basis until January 1, 1987). Therefore, for the period October 1, 1986 through December 31, 1986, the amount of Hospital X's outlier payment is calculated as follows:

Step 1.—Computation of Hospital X's Standardized Cost

Billed Charges—$100,000.00
National ratio of cost to charges—.71
Indirect medical education adjustment factor—7.871%
Disproportionate share hospital adjustment factor—5%
Hospital X's Standardized cost equals $100,000 divided by 1 plus (.07871 plus .05) times .71 equals $62,903.67

Step 2.—Determination of Cost Outlier Thresholds

Computation 1 (Based on Federal Rate)

DRG 31 Federal rate—$2338.22
Federal rate for threshold computation equals $2338.22
Federal rate, doubled—2×$2338.22 =$4676.44

Computation 2 (Based on Wage Index Adjusted Standard Cost Outlier Threshold)

Standard Cost Outlier Threshold—$13,500
- Labor-related share [1]—69.24%
- Nonlabor-related share, excluding capital[1]—23.03%
- Nonlabor-related share, capital only [1]—7.73%
- Wage index adjusted cost outlier threshold, including capital—($13,500 × .6924 × 1.6395) + ($13,500 × .2303) + ($13,500 × .0773) =$19,477.66
- Computation 1 result—$4,676.44
- Computation 2 result—$19,477.66
- Higher of computation 1 or computation 2—$19,477.66

Applicable cost outlier threshold—$19, 477.66

Step 3.—Calculation of Cost Outlier Payment

Outlier cost—$62,903.67−$19,477.66 =$43,426.01
Capital portion[1] of hospital cost from market basket—7.73% or .0773
Capital portion of outlier cost—$43,426.01×.0773=$3,356.83
Outlier cost, excluding capital[2]—$43,426.01−$3,356.83=$40,069.18
Federal portion of prospective payment rate—75%
Federal portion of outlier cost—.75×$40,069.18=$30,051.89
Marginal cost factor—.60
Outlier payment—.60×$30,051.89=$18,031.13

Step 4.—Cost outlier payment for indirect medical education costs

Intern and resident/Bed ratio—.1
Percentage add-on for indirect medical education—7.871%
Indirect medical education cost outlier payment—$18,031.13×.07871=$1,419.23

Step 5.—Cost outlier payment adjusted for disproportionate share hospital

Disproportionate share hospital percentage add-on—5%
Disproportionate share hospital outlier payment—$18,031.13×.05=$901.56

Step 6.—Total cost outlier payments:

Regular	$18,031.31
Indirect medical education	1,419.23
Disproportionate share hospital	901.56
Total	20,351.92

The above total amounts represent only the outlier payment amounts for the discharges and exclude the usual prospective payments that apply for both outlier and non-outlier cases.

For purposes of this rule, we are not proposing to revise the 60 percent marginal cost factor used to compute outlier payments. To date, the 60 percent factor represents our best estimate of the ratio of marginal cost (that is, the incremental change in the actual cost of care per unit of output) to average cost. Most of the available estimates of the ratio of marginal cost to average cost vary quite substantially from one study to another depending on the measure of hospital output (such as days, admissions, or services) and the time interval examined. Although the 60 percent marginal cost factor that we have adopted is in the upper range of the available estimates, and may be appropriate as an overall average, we are concerned that it may yield payments that tend to discourage hospitals from treating outlier cases that are unusually costly or require very long lengths of stay. Since we do not wish to discourage the treatment of severely ill Medicare patients who require particularly resource-intensive care, we are specifically soliciting comments on the propriety of the 60 percent marginal

[1] These market basket portions reflect the labor-related and nonlabor-related components as described in Table 2, column 2 in section IV of the addendum.

[2] The capital portion of the outlier cost is excluded because it is paid on a pass-through basis for the hospital in this example until January 1, 1987.

cost factor used to compute outlier payments, particularly with respect to its ability to compensate hospitals reasonably for unusually expensive outlier cases. Commenters should understand that any recommended increase in the marginal cost ratio that might be incorporated in the final rule on the FY 1987 prospective payment rates would also require a corresponding increase in the length of stay and cost outlier thresholds to ensure that total estimated outlier payments comprise five percent of anticipated prospective payments.

g. Costs of Malpractice Insurance. On April 1, 1986, we published an interim final rule in the **Federal Register** on payment for the cost of malpractice insurance (51 FR 11142). In that rule we adopted an apportionment methodology for determining reasonable cost reimbursement for hospital malpractice insurance costs. The new apportionment policy for hospitals (§ 405.457), which generally will recognize as allowable costs a larger proportion of malpractice costs than previous policy, divides total malpractice insurance premium cost into two components. The "administrative component" is included in the Administrative and General (A&G) cost center and is apportioned on the basis of the individual hospital's Medicare utilization rate. The "risk component" is apportioned on the basis of a formula that takes into account the individual hospital's utilization as well as the national Medicare patient utilization rate and the national Medicare malpractice loss ratio.

For purposes of updating the standardized amounts, the Federal rates already include sufficient costs to account for any changes made as a result of the April 1, 1986 interim final rule. The Federal rates are based on unaudited hospital cost reports from cost reporting periods that ended in 1981. Based on our review of the cost reports, it appears that a large number of hospitals, in order to preserve their rights to appeal the prior regulations (§ 405.452) that provided for separate apportionment of malpractice costs, included such costs in the A&G cost center (that is, in accordance with the Medicare reimbursement principles in effect prior to the June 1, 1979 final rule (effective for cost reporting periods beginning on or after July 1, 1979) which established the policy on separate apportionment of malpractice costs in § 405.452(a)(1)(ii)). The effect of this action on the part of hospitals is that the Federal rates reflect an amount for malpractice costs that is in excess of the amount that would have been recognized had hospitals, in completing their Medicare cost reports, generally adhered to the existing regulations providing for separate apportionment of Medicare malpractice costs.

We have included no adjustment in the update factor for malpractice insurance costs. Those hospitals that request adjustments to their base year costs will have their hospital specific rates adjusted under our malpractice regulation. We are not making any adjustment to the federal rates for malpractice, and we note that if such an adjustment were made, it would reduce the rates. This is because the federal rates are based upon 1981 unaudited cost reports, and about half the hospitals submitted those cost reports under the regulations in effect prior to 1979, which provided for greater malpractice payments than provided for by the current regulations. We expect the hospitals that submitted cost reports under the 1979 regulations would be those whose malpractice payments were either increased under the 1979 regulations or were minimally reduced by the 1979 regulations.

In addition, as we stated in the September 3, 1985 final rule (50 FR 35703), our analyses indicate that the Federal rates are overstated for a number of reasons. Furthermore, both the General Accounting Office and the Department's Office of the Inspector General have conducted studies showing that the Federal rates are overstated. In light of these findings, we believe that it would be inappropriate to increase the rates further to reflect a modification in policy concerning reimbursement of malpractice insurance costs.

B. Adjustments for Area Wage Levels and Cost-of-Living

This section contains an explanation of the application of two types of adjustments to the adjusted standardized amounts that will be made by the intermediaries in determining the prospective payment rates as described in section D below. For discussion purposes, it is necessary to present the adjusted standardized amounts divided into labor and nonlabor portions. Table 1, as we propose to revise it in this addendum, contains the actual labor-related and nonlabor-related shares that would be used to calculate the prospective payment rates.

1. Adjustment for Area Wage Levels

Section 1886(d)(2)(H) of the Act requires that an adjustment be made to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This adjustment is made by the intermediaries by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. The proposed revised wage index, which makes minor corrections (for the provision in section IV.D. of the preamble regarding hospitals in redesignated rural counties which are surrounded on all sides by urban counties) to the wage index published in the May 6, 1986 interim final rule, is set forth in Tables 4a and 4b of this addendum.

2. Adjustment for Cost of Living in Alaska and Hawaii

Section 1886(d)(5)(C)(iv) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States were included in the adjustment for area wages above. For FY 1987, the adjustment necessary for nonlabor-related costs for hospitals in Alaska and Hawaii would be made by the intermediaries by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. (We note that the adjustment factors are different from those in effect in FY 1986.)

Table of Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Alaska—All areas	1.25
Hawaii:	
Oahu	1.225
Kauai	1.175
Maui	1.20
Molokai	1.20
Lanai	1.20
Hawaii	1.15

Note.—The above factors are based on data obtained from the U.S. Office of Personnel Management.

C. DRG Weighting Factors

All inpatient hospital discharges are categorized according to a DRG as discussed in the September 1, 1983 interim final rule (48 FR 39760) and the September 3, 1985 final rule (50 FR 35647).

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in medical technology and treatment patterns that may affect the cost of providing inpatient care. Accordingly, section 1886(d)(4)(C) of the Act provides that, effective for discharges occurring in FY 1986, and no less often than once every four years thereafter, the Secretary "shall adjust

the classifications and weighting factors . . . to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources."

In compliance with the law, we published in the September 3, 1985 final rule (50 FR 35722) revised DRG weights that were recalibrated to reflect changes in resource consumption that had occurred subsequent to 1981 (the base-year data used to derive the initial DRG weights). Unlike the FY 1984 (48 FR 39876) and FY 1985 (49 FR 34780) series of DRG weights, which were largely developed from 1981 Medicare cost report data and billing records from a 20 percent sample of Medicare beneficiaries, the DRG weights in the September 3, 1985 final rule were constructed from the FY 1984 Part A Tape Bill (PATBILL) file, which is the universe of available inpatient bills for Medicare patients discharged in FY 1984. The most recent DRG weights were based exclusively on hospital charges for nearly 11 million patient stays. For a detailed explanation of the development of these charge-based DRG relative weights, we refer the reader to the discussion in the June 10, 1985 proposed rule (50 FR 24372) and the September 3, 1985 final rule (50 FR 35652).

However, as a result of a series of Congressional postponements as described earlier, the prospective payment changes published in the September 3, 1985 final rule, including the revised DRG relative weights, which were to be effective for discharges occurring on or after October 1, 1985, were postponed through April 30, 1986. We implemented the revised DRG relative weights published in the September 3, 1985 final rule effective with discharges occurring on or after May 1, 1986 (51 FR 16772).

We considered proposing to recalibrate the DRG weights using a later PATBILL data set (subsequent to FY 1984) in this proposed rule as recommended by ProPAC. However, we decided against this course of action.

The Conference Committee report to Pub. L. 98-21 (H.R. Rep. No. 47, 98th Cong., 1st Sess. 187 (1983)) clearly anticipated the use of discretion as to the frequency of DRG weight recalibration by stipulating that the DRG classifications and weighting factors be adjusted for FY 1986, and subsequently as necessary, but not less often than once every four years. We believe it is appropriate not to recalibrate annually because—

—Shifts in the consumption of hospital resources among DRGs, the very basis for recalibration, generally occur as a result of changes in medical technology and the adoption of new treatment methods. Typically, these changes occur gradually over time as the clinical efficacy or cost saving benefits of the new technology and procedures become apparent and are adopted by hospitals and physicians on a widespread basis. Therefore, frequent or annual recalibration of DRGs is unnecessary in light of the general pace of technological diffusion and its effect on inpatient hospital resource consumption; and

—To the extent that new procedures or treatment methods may be rapidly adopted because the benefits are immediately evident, and the effect is to alter significantly the resource intensity or scope of procedures included in a specific DRG, we believe that these changes are adequately accommodated under the current system by which DRG classification system changes are made as specified in § 412.10. Under that regulation HCFA issues classification changes in an annual notice published in the **Federal Register.** In addition to the classification changes, we are proposing to reweight the DRGs that are affected as a result of the reclassification changes.

We welcome any suggestions that commenters may have regarding the frequency of recalibration of DRG weights.

D. Calculation of Prospective Payment Rates for FY 1987 General Formula for Calculation of Prospective Payment Rates for Cost Reporting Periods Beginning on or after October 1, 1986 and Before October 1, 1987

Prospective Payment Rate = (Hospital-Specific Portion + Federal Portion) + (Hospital-Specific Capital Portion + Federal Capital Portion)

1. Hospital-Specific Portion

The hospital-specific portion of the prospective payment rate is based on a hospital's historical cost experience. For the first cost reporting period under prospective payment, a hospital-specific rate was calculated for each hospital, derived generally from the following formula:

Base year costs per discharge divided by 1981 case-mix index multiplied by updating factor equals Hospital-specific rate

For the first prospective payment cost reporting period, the hospital-specific portion equaled 75 percent of the hospital-specific rate.

For each subsequent transition period cost reporting period, the hospital-specific portion is derived as follows:

Previous period's Hospital-Specific Rate x Updating Factor x Blending Percentage x DRG Weight.

The blending percentage for cost reporting periods beginning in FY 1987 is 25 percent. For a more detailed discussion of the hospital-specific portion, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772).

a. Updating the Hospital-Specific Rates for FY 1987 Cost Reporting Periods. We are proposing to increase the hospital-specific rates by 0.5 percent for cost reporting periods beginning on or after October 1, 1986. As required by section 1886(e)(4) of the Act in conjunction with section 1886(b)(3)(B) of the Act, this is the same percentage increase (0.5 percent) that we are proposing to change the Federal rates for in FY 1987.

As we pointed out, we believe the FY 1986 rates were set too high. If we were to propose to correct the rates prospectively for the full amount of the overstatement, it would result in a reduction of the hospital-specific rates. For the same reasons that we have proposed not to reduce the FY 1987 Federal rates, we have decided that it is preferable to increase the rates by 0.5 percent.

b. Calculation of Hospital-Specific Portion. For hospital cost reporting periods beginning on or after October 1, 1986, the hospital-specific portion of a hospital's payment for a given discharge would be calculated by:

Step 1.—Multiplying the previous cost reporting period's hospital-specific rate, as described in the May 6, 1986 interim final rule, by the applicable update factor (1.005);

Step 2.—Multiplying the previous cost reporting period's hospital-specific rate by 25 percent; and

Step 3.—Multiplying the amount resulting from Step 2 by the specific DRG weighting factor applicable to the discharge. The result is the hospital-specific portion of the FY 1987 prospective payment for a given discharge.

c. New Providers. Hospitals that have not completed a 12-month cost reporting period under Medicare (either under current or previous ownership) prior to September 30, 1983 and meet the criteria in § 412.74 are considered new providers for purposes of the prospective payment system. Their prospective payment rates are computed solely on the basis of the Federal rates. Thus, new providers are paid a blend of 50 percent of the appropriate Federal regional rate and 50 percent of the Federal national rate for

discharges occurring on or after October 1, 1986 and before October 1, 1987.

2. Federal Portion

For cost reporting periods beginning on or after October 1, 1986 and before October 1, 1987, the Federal portion of the hospital's rate will be 75 percent of the hospital's Federal rate. Beginning with discharges occurring on or after October 1, 1986, the Federal rate is comprised of a blend of the appropriate Federal regional rate (50 percent) and the Federal national rate (50 percent). The Federal rates are determined as follows:

Step 1.—Selecting the appropriate regional and national adjusted standardized amount considering the location and urban and rural designation of the hospital (see Table 1, section IV of the addendum);

Step 2—Multiplying the labor-related portion of the standardized amount by the appropriate wage index;

Step 3.—For hospitals in Alaska and Hawaii, multiplying the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4.—Summing the amounts from step 2 and the nonlabor portion of the standardized amount (adjusted if appropriate under step 3); and

Step 5.—Multiplying the final amount from step 4 by the weighting factor corresponding to the appropriate DRG weight (see Table 5, section IV of the addendum).

3. Hospital-Specific Capital Portion

For hospital cost reporting periods beginning on or after October 1, 1986, the hospital-specific portion of a hospital's payment would be calculated by multiplying by 80 percent the lower of—

- Actual allowable capital-related costs for the hospital's cost reporting period beginning on or after October 1, 1986; or
- The sum of total payments as calculated by multiplying the hospital-specific capital-related rate by the applicable percentage for updating the prospective payment amounts (0.5 percent), and multiplying the product by the DRG weighting factor (see Table 5 in section IV of the addendum).

4. Federal Capital Portion

For hospital cost reporting periods beginning on or after October 1, 1986, the Federal capital portion of a hospital's payment for a given discharge would be calculated by:

Step 1.—Selecting the appropriate regional and national standardized capital amount considering the location and urban and rural designation of the hospital (See Table 1, section IV of the addendum.

Step 2.—For hospitals in Alaska and Hawaii, multiplying the appropriate regional and national capital amounts in Step 1 by the appropriate cost-of-living adjustment factor;

Step 3.—Multiplying the final amount from step 2 by the DRG weighting factor (see Table 5, section IV of the addendum).

III. Proposed Target Rate Percentages for Hospitals and Hospital Units Excluded From the Prospective Payment System

A. Background

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in § 405.463 of the regulations. Under these limits, an annual target amount (stated as inpatient operating cost per discharge) is set for each hospital, based on the hospital' own cost experience. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's next cost reporting period.

A hospital that has inpatient operating costs per discharge in excess of its target amount would be paid no more that that amount. However, a hospital that has inpatient operating costs less than its target amount would be paid its costs plus the lower of (1) 50 percent of the differences between the inpatient operating cost per discharge and the target amount, or (2) five percent of the target amount.

Each hospital's target amount is adjusted annually, before the beginning of its cost reporting period, by an applicable target rate percentage for the 12-month period, prorated based on calendar year target rate percentages. For cost reporting periods beginning in FY 1983 and FY 1984, the applicable target rate percentage was the estimated hospital market basket increase factor plus one percentage point. For cost reporting periods beginning in FY 1985, the applicable target rate percentage was the estimated hospital market basket increase factor plus one-quarter of one percentage point, as prescribed by section 1886(b)(3)(B) of the Act. Under section 9101 of Pub. L. 99-272, the applicable target rate percentage increase for cost reporting periods beginning on or after October 1, 1985 through September 30, 1986 is $\frac{5}{24}$ of one percent. Section 9101 of Pub. L. 99-272 provides that for purposes of updating the target rate for FY 1987, the FY 1986 increase will be deemed to have been one-half of one percent. However, for cost reporting periods beginning in FY 1987, and thereafter, the target rate percentage is adjusted by an update factor determined by the Secretary under section 1886(e)(4) of the Act considering the recommendations of ProPAC under section 1886(e)(2) of the Act and may not exceed the market basket percentage as determined under section 1886(b)(3)(B) of the Act.

B. Proposed Target Amounts for Cost Reporting Periods Beginning in FY 1987

For cost reporting periods beginning in FY 1987, we are proposing to increase each hospital's previous year's target amount by 0.5 percent. Under section 1886(b)(3)(B) of the Act, as amended by section 9101(b) of Pub. L. 99-272, the applicable percentage increase, for FYs 1987 and 1988, is determined pursuant to section 1886(e)(4) of the Act, and may not exceed the market basket increase. The same percentage increase, therefore, applies to the target rate amounts for hospitals and units excluded from the propective payment system as applies to the prospective payment rates for hospitals subject to that system.

C. ProPAC Recommendations

ProPAC recommends that for FY 1987, the target rate of increase limits for hospitals and units excluded from the prospective payment system be—

- Updated to reflect the projected increase in the hospital market basket (4.6–4.8 percent);
- Corrected for forecast errors in FY 1986 (−0.3 percent); and
- Adjusted for the policy target adjustment factor (−0.8 percent).

Our proposed target rate increase (0.5 percent) is very similar to ProPAC's recommendation. Our projected increase in the market basket of 3.6 percent is based on more recent data than ProPAC's estimate. Likewise, our forecast error projection of −0.4 percent and our net case mix change of −2.1 percent are based on more recent data.

We are also proposing to consider the policy target adjustment factor in updating the target rates. We would use the same policy target adjustment factor (−2.0 percent) for the excluded facilities as we are proposing to use for prospective payment hospitals as required under section 1886(e)(4) of the Act.

IV. Tables

This section contains the tables referred to throughout the premable to

this proposed rule and in this addendum. For purposes of this proposed rule and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1, 2, 3c, 3d, 4a, 4b, 5, 6 and 7 are presented below. The tables are as follows:

Table 1—Adjusted Standardized Amounts, Labor/Nonlabor/Capital
Table 2—Hospital Market Basket
Table 3a—Hospital Case Mix (September 1, 1983 final rule—48 FR 39847)
3b—Average Case-Mix Indexes by Hospitals Classification Group (September 1, 1983 final rule—48 FR 39871)
3c—Hospital Case-Mix Indexes for Cost Reporting Periods Beginning in Federal FY 1985
3d—Average Case-Mix Indexes by Hospital Classification Group FY 1985
Table 4a—Wage Index for Urban Areas
Table 4b—Wage Index for Rural Areas
Table 5—Diagnosis-Related Groups
Table 6—Grouper Changes
Table 7—Length-of-stay Percentiles

TABLE 1.—ADJUSTED STANDARIZED AMOUNT, LABOR/NONLABOR/CAPITAL

	Urban			Rural		
	Labor related	Nonlabor related	Capital	Labor related	Nonlabor related	Capital
1. New England (CT, ME, MA, NH, RI, VT)	2,267.05	811.45	180.25	2,040.11	617.84	157.10
2. Midle Atlantic (PA, NJ, NY)	2,143.06	785.35	223.16	2,068.88	631.81	174.45
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,220.72	728.18	228.29	1,895.47	515.17	161.26
4. East North Central (IL, IN, MI, OH, WI)	2,318.76	855.84	246.96	1,885.09	578.86	165.20
5. East South Central (AL, KY, MS, TN)	2,094.37	645.52	234.42	1,885.62	481.66	147.84
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	2,147.35	761.73	229.40	1,757.45	496.92	136.94
7. West South Central (AR, LA, OK, TX)	2,171.96	712.84	247.63	1,768.13	480.73	140.47
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,097.88	772.16	303.09	1,740.64	538.65	137.90
9. Pacific (AK, CA, HI, OR, WA)	2,083.58	884.05	274.86	1,752.38	625.80	164.33
10. National	2,194.80	788.96	240.71	1,835.23	527.88	149.08

TABLE 2.—HOSPITAL MARKET BASKET

[1986 Relative Importance Weights]

Expense Categories	Excluding Capital [1]	Including Capital
1. Wages and Salaries [2]	57.65	53.20
2. Employee Benefits [2]	10.21	9.42
3. Professional Fees [2]	.79	.73
4. Captial		7.73
a. Depreciation		4.50
(1) Fixed Equipment		3.35
(2) Moveable Equipment		1.15
b. Interest		2.46
c. Other		.77
5. Energy and Utilities	2.26	2.07
a. Fuel, Oil, Coal, and Other Petroleum	.61	.56
b. Electricity	1.03	.95
c. Natural Gas	.36	.33
d. Motor Gasoline	.22	.20
e. Water and Sewage	.04	.03
6. Malpractice Insurance	1.00	.92
7. All Other	28.09	25.93
All Other Products	19.28	17.81
a. Pharmaceuticals	4.45	4.11

TABLE 2.—HOSPITAL MARKET BASKET—Continued

[1986 Relative Importance Weights]

Expense Categories	Excluding Capital [1]	Including Capital
b. Food	3.30	3.05
(1) Contract Service	1.28	1.18
(2) Direct Purchase	2.02	1.86
c. Chemicals and Cleaning Products	2.40	2.22
d. Surgical and Medical Instruments	2.12	1.95
e. Photographic Supplies	2.07	1.91
f. Rubber and Plastics	1.85	1.71
g. Paper Products	1.06	.98
h. Apparel	.97	.90
i. Minor Machinery Equipment	.40	.37
j. Miscellaneous Products	.66	.61
All Other Services	8.81	8.12
a. Business Services [2]	3.06	2.82
b. Computer and Data Processing Services [2]	1.58	1.45

TABLE 2.—HOSPITAL MARKET BASKET—Continued

[1986 Relative Importance Weights]

Expense Categories	Excluding Capital [1]	Including Capital
c. Transportation and Shipping	.99	.91
d. Telephone	.81	.74
e. Blood Services [2]	.47	.43
f. Postage [2]	.30	.28
g. All Other Services Labor Intensive [2]	.98	.91
h. All Other Services: Nonlabor Intensive	.62	.58
Total	100.00	100.00

[1] These weights are used to develop the revised labor-related/nonlabor-related components of the standardized rates in Table 1, excluding capital.
[2] Considered labor-related.

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PROVIDER	CASE MIX
010001	1.0743
010004	1.0098
010005	1.1379
010006	1.0846
010007	0.9251
010008	1.0240
010009	0.9915
010010	0.9898
010011	1.1317
010012	1.1200
010015	1.0377
010016	1.1132
010017	1.0351
010018	0.7696
010019	1.0201
010020	0.9967
010021	1.0325
010022	1.0211
010023	1.0987
010024	1.1007
010025	1.0735
010026	0.9271
010027	0.9303
010028	0.9772
010029	1.1347
010030	0.9613
010031	1.0701
010032	0.9358
010033	1.7287
010034	0.9961
010035	1.0409
010036	1.0091
010038	0.9899
010039	1.3660
010040	1.1342
010041	0.8466
010043	0.9257
010044	0.8849
010045	0.9549
010046	1.0983
010047	0.9976
010049	1.0007
010050	0.9437
010051	0.8446
010052	0.9711
010053	1.0603
010054	1.0975
010055	1.0549
010056	1.1739
010057	0.9732
010058	1.1208
010059	0.9007
010060	0.9489
010061	0.9662
010062	0.9089
010064	1.3557
010065	1.0607
010066	0.8659
010067	0.8591
010068	1.0946
010069	1.1088
010070	1.2208
010072	1.0926
010073	0.9628
010074	0.8902
010075	1.0098
010078	1.1592
010079	1.0276
010080	0.9607
010081	1.3585
010083	0.9785
010084	1.1269
010085	1.1170
010086	0.9625
010087	1.2241
010089	1.0095
010090	1.1846
010091	1.0312
010092	1.2756
010094	0.9738
010095	0.9687
010096	0.9623
010097	0.9489
010098	1.0288
010099	1.0195
010100	1.1642
010101	0.9951
010102	0.8986
010103	1.3032
010104	1.3516
010108	1.0095
010109	1.0956
010110	0.8728
010111	0.8831
010112	1.0535
010113	1.3095
010114	1.0884
010115	0.9905
010117	0.9316
010118	1.1116
010119	1.0969
010120	0.9443
010121	1.0204
010122	0.9506
010123	1.1086
010124	1.0196
010125	0.9099
010126	0.9753
010127	1.0764
010128	1.0322
010129	1.0431
010130	1.0510
010131	1.0579
010133	0.9962
010134	0.9421
010136	1.0288
010137	1.1640
010138	0.9527
010139	1.3971
010142	0.8421
010143	1.0643
010144	1.0873
010145	1.0784
010146	1.0540
010148	0.9596
010149	1.1721
010150	0.9629
010152	1.1240
020001	1.2840
020002	0.9768
020004	1.0799
020005	1.0379
020006	1.0561
020007	0.8447
020008	0.9981
020009	0.8400
020010	0.9279
020011	0.9114
020012	1.0862
020013	0.9042
020014	0.9517
020016	0.9690
020017	1.0855
020018	0.9699
020020	0.9379
020021	1.0588
020024	0.9423
020025	0.9404
020026	1.1922
020027	0.9390
030001	1.1899
030002	1.4196
030003	1.1593
030004	0.9102
030006	1.3896
030007	1.1154
030008	1.2323
030009	1.1894
030010	1.2988
030011	1.1696
030012	1.0781
030013	1.3052
030014	1.2324
030016	1.1061
030017	1.2045
030018	1.2686
030019	1.0948
030020	1.2615
030022	1.2224
030023	1.2391
030024	1.4053
030025	1.0562
030026	0.8279
030027	0.9946
030030	1.2519
030033	1.0571
030034	1.0476
030035	1.1386
030036	1.1489
030037	1.6949
030038	1.2795
030040	1.0212
030041	0.9522
030043	1.0917
030044	1.0269
030046	1.0729
030047	0.9285
030048	0.9768
030049	0.9886
030051	1.0791
030054	0.9081
030055	1.0170
030057	1.1580
030059	1.2066
030060	1.2801
030061	1.2364
030062	1.0241
030063	0.9952
030064	1.4274
030065	1.3155
030067	1.0227
030068	0.9811
030069	1.1591
030071	0.9216
030072	0.9581
030073	1.0941
030074	0.8521
030076	0.9856
030077	0.9070
030078	1.1102
030079	0.9545
030080	1.2245
030081	0.9224
030082	0.7854
030083	1.1830
030084	0.9970
030085	1.0407
030086	1.0350
030087	1.1348
030088	1.1253
040001	1.0468
040002	0.9674
040003	1.0185
040004	1.1370
040005	0.9734
040006	0.9899
040007	1.2436
040008	1.0393
040009	0.9983
040010	1.1099
040011	0.9510
040013	1.0228
040014	1.0824
040015	0.9938
040016	1.2057
040017	1.1073
040018	1.0686
040019	0.9940
040020	1.1388
040021	1.0472
040022	1.1056
040024	0.9420
040025	0.9259
040026	1.1634
040027	1.1040
040028	1.0109
040029	1.0074
040030	0.9352
040031	1.0100
040032	0.9872

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
040033	0.8880	040107	0.9773	050049	1.1217	050108	1.2507	050168	1.3832
040035	0.9696	040108	0.8764	050051	1.0274	050109	1.7693	050169	1.2740
040036	1.0858	040109	1.0455	050052	1.0731	050110	1.0823	050170	1.1884
040037	1.0348	040113	0.9350	050053	1.2187	050111	1.2545	050172	1.1406
040039	0.9488	040114	1.4279	050054	1.1505	050112	1.3160	050173	1.2230
040040	0.9578	040115	0.9851	050055	1.1793	050113	1.1066	050174	1.4697
040041	1.0912	040116	1.1020	050056	1.1446	050114	1.2658	050175	1.1358
040042	1.1777	040118	1.0156	050057	1.1958	050115	1.2555	050177	1.2746
040043	0.9627	040119	1.0535	050058	1.2144	050116	1.3345	050179	1.1206
040044	0.9290	040122	0.9505	050060	1.2524	050117	1.1968	050180	1.2397
040045	0.9046	040123	0.9825	050061	1.1745	050118	1.1665	050181	1.1371
040047	1.0710	040124	1.0062	050063	1.2108	050119	1.0076	050183	1.1085
040048	1.0755	040126	0.9203	050065	1.3010	050121	1.0769	050186	1.2002
040050	0.9999	040127	0.8681	050066	1.2103	050122	1.1911	050187	1.0682
040051	0.9317	050002	1.1501	050067	1.1683	050124	1.2401	050188	1.2197
040053	0.9760	050004	1.1251	050068	1.1045	050125	1.2244	050189	0.9729
040054	0.9863	050006	1.2380	050069	1.3812	050126	1.2520	050190	1.1677
040055	1.2120	050007	1.3447	050070	1.1919	050127	1.1862	050191	1.2654
040058	0.9553	050008	1.2336	050071	1.1886	050128	1.2560	050192	1.0475
040060	0.9936	050009	1.2799	050072	1.2407	050129	1.4256	050193	1.1897
040062	1.1858	050010	0.9929	050073	1.1659	050131	1.2164	050194	1.1465
040063	1.1885	050011	1.0468	050074	0.9241	050132	1.1654	050195	1.1271
040064	0.9685	050013	1.6136	050075	1.2435	050133	1.1283	050196	1.2094
040066	0.9369	050014	1.1623	050076	1.4367	050134	1.1048	050197	1.5342
040067	0.9685	050015	1.2622	050077	1.3684	050135	1.1836	050198	1.1397
040068	1.0410	050016	1.0862	050078	1.1669	050136	1.1637	050200	1.1887
040069	1.0381	050017	1.5423	050079	1.2039	050137	1.1403	050201	1.0966
040070	0.9026	050018	1.1127	050080	1.1982	050138	1.4374	050202	1.1934
040071	1.1605	050019	0.8912	050081	1.3850	050139	1.1625	050204	1.2494
040072	1.0170	050021	1.1858	050082	1.2093	050140	1.1480	050205	1.1875
040074	1.0298	050022	1.2183	050084	1.3423	050141	1.1237	050207	1.1813
040075	1.0136	050024	1.1146	050086	1.0898	050143	1.1123	050208	1.1809
040076	0.9610	050025	1.4391	050087	1.2311	050144	1.3245	050210	0.7098
040077	0.9078	050026	1.2595	050088	1.1096	050145	1.2203	050211	1.2364
040078	1.1764	050028	1.1877	050089	1.1632	050147	0.9291	050212	1.1041
040080	0.9811	050029	1.1717	050090	1.1265	050148	1.0037	050213	1.1959
040081	0.8617	050030	1.1395	050091	1.1951	050149	1.1632	050214	1.1975
040082	1.0843	050032	1.0535	050092	1.0699	050150	1.2450	050215	1.3456
040084	1.0005	050033	1.3030	050093	1.3666	050151	1.2119	050217	1.1619
040085	0.9416	050034	1.1983	050095	1.0112	050152	1.1912	050219	1.2463
040087	0.9805	050036	1.1930	050096	1.1339	050153	1.4137	050220	1.0825
040088	1.1025	050038	1.2376	050097	1.1824	050154	1.1670	050221	1.1993
040090	0.9480	050039	1.3813	050098	1.1179	050155	1.0824	050222	1.1791
040091	0.9761	050040	1.0710	050099	1.2297	050156	1.1430	050224	1.2120
040093	0.9564	050041	1.0748	050100	1.7818	050158	1.4561	050225	1.1585
040095	0.9797	050042	1.1490	050101	1.2306	050159	1.1914	050226	1.4567
040098	1.1149	050043	1.4899	050102	1.2568	050161	1.1072	050228	1.2249
040100	1.1125	050045	1.0976	050103	1.3388	050164	1.2414	050229	1.1865
040105	1.0190	050046	1.1293	050104	1.2742	050166	1.2632	050230	1.2159
040106	0.9980	050047	1.4418	050107	1.1511	050167	1.2236	050231	1.1960

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
050232	1.4834	050301	1.1823	050377	1.0862	050442	1.1501	050527	1.0845
050233	1.1272	050302	1.2335	050378	1.1030	050443	0.9696	050528	1.0785
050234	1.1828	050303	1.1029	050379	1.0230	050444	1.1370	050530	1.2053
050235	1.3123	050305	1.1968	050380	1.5858	050446	0.9264	050531	1.2125
050236	1.1582	050307	1.2221	050381	0.8823	050447	1.2813	050534	1.2123
050238	1.1936	050308	1.3671	050382	1.1114	050448	0.9786	050535	1.1266
050239	1.2380	050309	1.1703	050383	1.1264	050449	1.1145	050537	1.1813
050240	1.1691	050310	1.1628	050385	1.2033	050450	0.8235	050539	1.1624
050241	1.1835	050312	1.2867	050387	1.0168	050451	0.9093	050541	1.3472
050242	1.2939	050313	1.0619	050388	0.9550	050454	1.6571	050542	1.0183
050243	1.1680	050315	1.1841	050390	1.2225	050455	1.3328	050543	1.0998
050245	1.3785	050317	1.1151	050391	1.1550	050456	1.2997	050544	1.1280
050248	1.0582	050318	0.8908	050392	0.9581	050457	1.3887	050545	0.7795
050251	1.0291	050319	1.2317	050393	1.2569	050458	0.8742	050546	0.8242
050253	1.1048	050320	1.1492	050394	1.3073	050459	1.2367	050547	0.9529
050254	1.1591	050324	1.4360	050395	1.0456	050464	1.5212	050549	1.4384
050256	1.4071	050325	1.1516	050396	1.3893	050467	1.1484	050550	1.2679
050257	1.1624	050326	1.1648	050397	0.9738	050468	1.2085	050551	1.2672
050258	1.2748	050327	1.4436	050401	1.2295	050469	1.0011	050552	1.1537
050260	1.0473	050328	1.0675	050403	1.1331	050470	1.0687	050557	1.1980
050261	1.1593	050329	1.1724	050404	1.0242	050471	1.2500	050559	1.2040
050262	1.4196	050331	1.1410	050405	1.1187	050473	1.2023	050560	1.1896
050263	1.1399	050333	0.9560	050406	0.9475	050476	1.0757	050561	1.0948
050264	1.2064	050334	1.1892	050407	1.1249	050477	1.0752	050562	1.1077
050267	1.3965	050335	1.0567	050410	1.0363	050478	1.2390	050564	1.1872
050268	1.2500	050336	1.1675	050411	1.1680	050481	1.1294	050565	1.0883
050269	1.1325	050337	1.1671	050413	1.1982	050482	1.0261	050566	0.9872
050270	1.2090	050342	1.2037	050414	1.1157	050483	1.1762	050567	1.1983
050272	1.2357	050343	1.1154	050415	1.0166	050485	1.3215	050568	1.2055
050273	0.9680	050345	1.2514	050417	1.0972	050486	1.2448	050569	1.1786
050274	0.8757	050348	1.2758	050418	1.1021	050487	1.1650	050570	1.4774
050276	1.0631	050349	1.0283	050419	1.1608	050488	1.2134	050571	1.1952
050277	1.1752	050350	1.2466	050420	1.1442	050489	1.1816	050573	1.3473
050278	1.1739	050351	1.3635	050421	1.1874	050491	1.1980	050575	1.0749
050279	1.1574	050352	1.1186	050423	1.0200	050492	1.0920	050576	1.2298
050280	1.1925	050353	1.4743	050424	1.2667	050494	1.0530	050577	1.1995
050281	1.2667	050355	0.9794	050425	1.1852	050496	1.5090	050578	1.1303
050282	1.1709	050357	1.3985	050426	1.1638	050497	1.0193	050579	1.0777
050283	1.1978	050359	1.0873	050427	0.8887	050498	1.1426	050580	1.1821
050286	1.0846	050360	1.2017	050428	0.8055	050502	1.7226	050581	1.2252
050289	1.5546	050361	0.9988	050430	0.9349	050503	1.2296	050583	1.6770
050290	1.2317	050362	1.1786	050431	1.0882	050506	1.2077	050584	1.1824
050291	1.1453	050363	1.1086	050432	1.3601	050510	1.1766	050585	1.2374
050292	1.1767	050366	1.0823	050433	0.9957	050512	1.1752	050586	1.1550
050293	0.8837	050367	1.1637	050434	1.1308	050515	1.2092	050587	1.1374
050295	1.1588	050369	1.1675	050435	1.1916	050516	1.2440	050588	1.1664
050296	1.1028	050371	1.1072	050436	1.0412	050517	1.1427	050589	1.2209
050298	1.0771	050372	1.1190	050438	1.3652	050522	1.1425	050590	1.2168
050299	1.2615	050373	1.0485	050440	1.2062	050523	1.1360	050591	1.1869
050300	1.1401	050376	1.2019	050441	1.5573	050526	1.1523	050592	1.1654

PROVIDER	CASE MIX
050593	1.1408
050594	1.9701
050597	1.1446
050598	1.1515
050599	1.2614
050601	1.1619
050603	1.2652
050604	1.1983
050605	0.8944
050607	1.1786
050608	1.1347
050609	1.1906
050613	1.0008
050615	1.1793
050616	1.0954
050618	0.9963
050619	1.2046
050622	1.1292
050623	1.0917
050624	1.1872
050625	1.3262
050630	1.0807
050633	1.1758
050635	1.1911
050636	1.2086
050637	1.0780
050638	1.1429
050641	1.1406
050643	0.8116
050644	1.1091
050649	1.0617
050650	1.0873
050651	1.1383
050657	1.0502
050661	1.1979
050662	1.4403
050663	1.0948
050667	1.0834
050669	0.8598
060001	1.2056
060003	1.1492
060004	1.0738
060005	1.2231
060006	1.2583
060007	1.1245
060008	1.0736
060009	1.2276
060010	1.3145
060011	1.1010
060012	1.2618
060013	1.1714
060014	1.2250
060015	1.2282
060016	1.1774
060017	1.1892
060018	1.1007
060019	1.1855
060020	1.2382
060022	1.4473
060023	1.2470
060024	1.3997
060025	0.9614
060026	1.2330
060027	1.1783
060028	1.2846
060029	1.0085
060030	1.1342
060031	1.2215
060032	1.2690
060033	1.1830
060034	1.1766
060035	1.1084
060036	1.1682
060037	0.9608
060038	1.0215
060039	1.0443
060041	0.9540
060042	1.0922
060043	1.0897
060044	1.0964
060045	1.1059
060046	1.1131
060047	0.9080
060049	1.1855
060050	1.1916
060051	1.1698
060052	0.9014
060053	0.8630
060054	1.1448
060055	0.8924
060056	0.9443
060057	0.9516
060058	0.9516
060060	1.0301
060062	0.9776
060063	1.1557
060064	1.2516
060065	1.0814
060066	0.9747
060067	1.0251
060068	1.0650
060070	1.0318
060071	1.2062
060072	1.0527
060073	0.9734
060074	0.8905
060075	1.2336
060076	1.1233
060077	1.0132
060085	0.9440
060087	1.0784
060088	1.0466
060090	0.9780
060092	1.0031
060093	0.7246
060096	1.0556
060097	0.8400
060098	1.1747
070001	1.3757
070002	1.4285
070003	1.0874
070004	1.0524
070005	1.1517
070006	1.1390
070007	1.1269
070008	1.0492
070009	1.0443
070010	1.2996
070011	1.0238
070012	1.1453
070013	1.1657
070014	1.0504
070015	1.0309
070016	1.1059
070017	1.1636
070018	1.0973
070019	1.0455
070020	1.1332
070021	1.0723
070022	1.3258
070023	1.0596
070024	1.0553
070025	1.3902
070026	1.0791
070027	1.1950
070028	1.1710
070029	1.1028
070030	1.0422
070031	1.1759
070033	1.1133
070034	1.1438
070035	1.2161
070036	1.2185
080001	1.2071
080002	1.1000
080003	1.1887
080004	1.2136
080005	1.1007
080006	1.0838
080007	1.1085
090001	1.2854
090002	1.0935
090003	1.2911
090004	1.4815
090005	1.1835
090006	1.2086
090007	1.0923
090008	1.1760
090009	1.1607
090010	1.0734
090011	1.4470
100001	1.1760
100002	1.1879
100004	0.8991
100005	1.0659
100006	1.2545
100007	1.4232
100008	1.2250
100009	1.2342
100010	1.1755
100011	1.0051
100012	1.2007
100013	0.8798
100014	1.1264
100015	1.1251
100016	0.9935
100017	1.1757
100018	1.1507
100019	1.1396
100020	1.1405
100021	1.1211
100022	1.3406
100023	1.0668
100024	1.1510
100025	1.3412
100026	1.2344
100027	0.9070
100028	1.1146
100029	1.1279
100030	1.0320
100031	1.0240
100032	1.2190
100033	1.1378
100034	1.2640
100035	1.1661
100036	1.1230
100038	1.2600
100039	1.1929
100040	1.3007
100042	0.9969
100043	1.2260
100044	1.1577
100045	1.1733
100046	1.1312
100047	1.1129
100048	0.9025
100049	1.1331
100050	1.0501
100051	1.0242
100052	1.1938
100053	1.1395
100054	1.0784
100055	1.0908
100056	1.1196
100057	1.0746
100059	1.2179
100060	1.3753
100061	1.1657
100062	1.1833
100063	1.1301
100065	1.0794
100067	1.1626
100068	1.1604
100069	1.1199
100070	1.2033
100071	1.1008
100072	1.0902
100073	1.3275
100074	1.1266
100075	1.3559
100076	1.1190
100077	1.1268
100078	0.9822
100079	1.0710
100080	1.1643
100081	0.9146
100082	1.1806
100083	1.1170
100084	1.0449
100085	1.0331

PROVIDER	CASE MIX
100086	1.1313
100087	1.3614
100088	1.3026
100089	1.1351
100090	1.1427
100092	1.1044
100093	1.1453
100098	0.9367
100099	1.1044
100100	1.0603
100102	1.0587
100103	0.9027
100105	1.1084
100106	1.0144
100107	1.0908
100108	0.9360
100109	1.0563
100110	1.0952
100112	0.9985
100113	1.4789
100114	1.1235
100115	1.0842
100117	1.0962
100118	1.0749
100120	0.9812
100121	1.0521
100122	0.9957
100124	1.0513
100125	1.1205
100126	1.2126
100127	1.1994
100128	1.9125
100129	1.1224
100130	1.1134
100131	1.0818
100132	1.1556
100134	0.8713
100135	1.2718
100137	1.0519
100138	0.9479
100139	1.0365
100140	1.0344
100142	0.9877
100143	1.0149
100144	0.9820
100145	1.1363
100146	0.9623
100147	1.0076
100149	1.1373
100150	1.0364
100151	1.3676
100152	1.0980
100153	0.8199
100154	1.3469
100156	1.0391
100157	1.2535
100159	0.9138
100160	1.0597
100161	1.1670
100162	1.1428
100164	0.9755
100165	1.0500
100166	1.1394
100167	1.1274
100168	1.1360
100169	1.4279
100170	1.1319
100172	1.0187
100173	1.1153
100174	1.2506
100175	0.9632
100176	1.3453
100177	1.1505
100179	1.3408
100180	1.2290
100181	1.0619
100183	1.0507
100185	1.0944
100186	1.1960
100187	1.1155
100189	1.1401
100191	1.1639
100193	0.8166
100194	1.0955
100195	1.1033
100196	1.1948
100199	1.1186
100200	1.1346
100203	1.1568
100204	1.2753
100206	1.1400
100207	1.1342
100208	1.1030
100209	1.1942
100210	1.2876
100211	1.1326
100212	1.1037
100213	1.1985
100214	1.0903
100217	1.0288
100218	1.0368
100219	1.1729
100220	1.2383
100221	1.3934
100222	1.0278
100223	1.0841
100224	1.1151
100225	1.1005
100226	1.0650
100227	0.9413
100228	1.0875
100229	1.1026
100230	1.0922
100231	1.3665
100232	1.0630
100234	1.1808
100235	1.2007
100236	1.1648
100237	1.4891
100238	1.1349
100239	1.2641
100240	0.7229
100241	0.8906
100242	1.1278
100243	1.1093
100244	1.0944
100246	1.1983
100248	1.3353
100249	1.0609
100252	1.0566
100253	1.1689
100254	1.1165
100255	1.1398
100256	1.1242
100258	1.0915
100259	1.1048
100260	1.1352
100262	1.1369
110001	1.0755
110002	1.0595
110003	1.0574
110004	1.0662
110005	1.0178
110006	1.1535
110007	1.2241
110008	1.0601
110009	0.9573
110010	1.7102
110011	1.0389
110013	0.9679
110014	0.8844
110015	0.9864
110016	1.1179
110017	0.9745
110018	1.0584
110020	1.0485
110023	1.0747
110024	1.1518
110025	1.1237
110026	0.9682
110027	0.9674
110028	1.3746
110029	1.0887
110030	1.0161
110031	1.1147
110032	1.0462
110033	0.9957
110034	1.1772
110035	1.0934
110036	1.4035
110037	0.8816
110038	1.1268
110039	1.1085
110040	0.9473
110041	1.0379
110042	0.9982
110043	1.1918
110044	1.1112
110045	1.0146
110046	0.9807
110047	0.8696
110048	1.0183
110049	0.8933
110050	0.9717
110051	0.9200
110052	0.8894
110054	1.1466
110055	0.8738
110056	0.9618
110059	1.0220
110061	0.8800
110062	0.9372
110063	1.0060
110064	1.1502
110065	0.8880
110066	1.2186
110069	1.0634
110070	0.8988
110071	0.9352
110072	0.9185
110073	0.9106
110074	1.1481
110075	1.0718
110076	1.2161
110077	0.9094
110078	1.3430
110079	1.0703
110080	1.1145
110081	0.9801
110082	1.6979
110083	1.1283
110085	1.0998
110086	1.1035
110087	1.0430
110088	0.8902
110089	1.0348
110091	1.1990
110092	0.9966
110093	1.0070
110094	0.8786
110095	1.1113
110096	1.0039
110097	0.8739
110098	0.9459
110099	0.8738
110100	1.0017
110101	0.9134
110103	0.9477
110104	1.0457
110105	1.0885
110107	1.3130
110108	0.8918
110109	0.9503
110111	0.9077
110112	0.9011
110113	0.9446
110114	1.0037
110115	1.2924
110117	0.8968
110118	1.0096
110120	0.9652
110121	0.9323
110122	1.1595
110123	1.0368
110124	0.9837
110125	1.0621
110127	0.9448
110128	1.0856
110129	1.2744
110130	0.8822

PROVIDER	CASE MIX
110131	0.9043
110132	0.9486
110133	0.9125
110134	0.8839
110135	0.9145
110136	0.9577
110140	0.9214
110141	0.9118
110142	0.8507
110143	1.0753
110144	1.0947
110146	0.8845
110149	0.9511
110150	1.0760
110151	1.0103
110152	0.9771
110153	0.9171
110154	0.8979
110155	0.9857
110156	0.9015
110157	1.0311
110158	0.9728
110161	1.2205
110162	0.8905
110163	1.1791
110164	1.1720
110165	1.1379
110166	1.0943
110168	1.1133
110169	0.6555
110170	0.8022
110171	1.1228
110172	1.0817
110174	0.9020
110175	1.0335
110176	1.0581
110177	1.0983
110178	0.7106
110179	1.0767
110181	0.9596
110183	1.0614
110184	1.0907
110185	0.9049
110186	1.0086
110187	0.9851
110188	1.0961
110189	0.9098
110190	1.0208
110191	1.0955
110192	1.0785
110193	1.0394
110194	0.9447
110195	1.0543
110198	1.1949
120001	1.3675
120002	1.1113
120003	0.9758
120004	1.1460
120005	1.1135
120006	1.1010
120007	1.2960
120008	1.0114
120009	0.9424
120010	1.3810
120011	1.2845
120012	0.9562
120014	1.0951
120015	0.8611
120016	1.0286
120018	0.8185
120019	1.0327
120021	0.8933
120022	1.3714
130001	1.0615
130002	1.2132
130003	1.1357
130005	1.1594
130006	1.5119
130007	1.2675
130008	0.9023
130009	0.9525
130010	0.8440
130011	1.0935
130012	0.8737
130013	1.0884
130014	1.1656
130015	0.9963
130016	0.9409
130017	0.9126
130018	1.1574
130019	1.0746
130021	0.9287
130022	1.0297
130024	1.0820
130025	1.0363
130026	1.0471
130027	0.9205
130028	1.1241
130029	1.0613
130030	0.8550
130031	1.0056
130032	0.9550
130034	0.9064
130035	1.0227
130036	1.1691
130037	1.0002
130038	0.9194
130039	1.1069
130040	0.9425
130041	0.9126
130043	0.9732
130044	0.8390
130045	0.9488
130048	1.0078
130049	1.0913
130051	0.9151
130053	0.8827
130054	0.8347
140001	0.9992
140002	1.1749
140003	0.9082
140004	1.0448
140005	0.8884
140007	1.1132
140008	1.1328
140009	0.9866
140010	1.2106
140011	1.0419
140012	1.1716
140013	1.1135
140014	0.9771
140015	1.1099
140016	1.0448
140017	1.0958
140018	1.2211
140019	0.9286
140023	1.0132
140024	0.9621
140025	1.0972
140026	1.0860
140027	1.0253
140029	1.1700
140030	1.2033
140031	1.0838
140032	1.0411
140033	1.0805
140034	1.0078
140035	1.0791
140036	0.9856
140037	0.9906
140038	1.0370
140039	1.0246
140040	1.0615
140041	0.9911
140042	0.9467
140043	1.0873
140045	0.9609
140046	1.0829
140047	1.0230
140048	1.1114
140049	1.1391
140051	1.1244
140052	1.1093
140053	1.4019
140054	1.1451
140055	0.9300
140058	1.0245
140059	0.9813
140061	1.0072
140062	1.0945
140063	1.1105
140064	1.1106
140065	1.1595
140066	1.0082
140067	1.2897
140068	1.0294
140069	1.1027
140070	1.1066
140072	1.1330
140074	1.0491
140075	1.2111
140077	0.9754
140079	1.1067
140080	1.5310
140081	1.0481
140082	1.1290
140083	1.0519
140084	1.1474
140085	1.0958
140086	1.0011
140087	1.0977
140088	1.3425
140089	1.0530
140090	1.2068
140091	1.2136
140093	1.0252
140094	1.0533
140095	1.1472
140097	1.0784
140098	1.1190
140099	1.0635
140100	1.0099
140101	1.0348
140102	0.9320
140103	1.1206
140104	1.0097
140105	1.1934
140107	0.9324
140108	1.0655
140109	1.0034
140110	1.1046
140111	1.0285
140112	0.9975
140113	1.3206
140114	1.0793
140115	0.9817
140116	1.1865
140117	1.1168
140118	1.3200
140119	1.3875
140120	1.0523
140121	0.9213
140122	1.1385
140123	1.0933
140124	1.0094
140125	1.0855
140126	1.3178
140127	1.1247
140128	1.0618
140129	1.0588
140130	1.0806
140131	1.0822
140132	1.2120
140133	1.1565
140134	1.2423
140135	1.0747
140136	0.9586
140137	0.9821
140138	0.9656
140139	1.0345
140140	1.0467
140141	0.9861
140142	1.0453
140143	1.0453
140144	1.0062
140145	1.0986
140146	0.8953
140147	0.9978
140148	1.2844
140150	1.1870

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
140151	0.9909	140209	1.2569	140291	1.1151	150049	1.0450	150104	1.1168
140152	0.9820	140210	1.0120	140292	1.1292	150050	1.0730	150105	1.0449
140153	1.1651	140211	1.0302	140293	1.0761	150051	1.1330	150106	0.9838
140154	1.1266	140212	0.9739	140294	0.9318	150052	0.9203	150109	1.1967
140155	1.0313	140213	1.0784	140295	1.0685	150053	0.9884	150110	0.9437
140156	1.1611	140215	1.0300	140298	1.1291	150054	1.0080	150111	1.0588
140157	0.9400	140216	0.8892	150001	1.0805	150056	1.3881	150112	1.1310
140158	1.1664	140217	1.1130	150002	1.0990	150057	0.8265	150113	1.0788
140159	1.0485	140218	1.0965	150003	1.2878	150058	1.2646	150114	0.9631
140160	1.1208	140219	1.0287	150004	1.1880	150059	1.0626	150115	1.1930
140161	1.0307	140220	1.0553	150005	1.1134	150060	1.0212	150122	1.0232
140162	1.0223	140223	1.2717	150006	1.1376	150061	1.1163	150123	0.9616
140163	0.9468	140224	1.1161	150007	1.0170	150062	0.9596	150124	1.0634
140164	1.1367	140226	0.9628	150008	1.2911	150063	1.0717	150125	1.1196
140165	0.8919	140228	1.3216	150009	1.0896	150064	1.0394	150126	1.5284
140166	1.0421	140229	0.9937	150010	1.0500	150065	1.1086	150127	1.0856
140167	1.0152	140230	0.9760	150011	1.1313	150066	1.0067	150128	1.1073
140168	1.0814	140231	1.1715	150012	1.2556	150067	1.0204	150129	1.1057
140170	1.0063	140232	0.9803	150013	1.0118	150069	1.1035	150130	1.0718
140171	0.9397	140233	1.2945	150014	1.1768	150070	1.0434	150132	1.2482
140172	1.1962	140234	1.0101	150015	1.1058	150071	1.1016	150133	1.0755
140173	0.9902	140235	0.9597	150017	1.4030	150072	1.1344	150134	1.0452
140174	1.1603	140236	1.0566	150018	1.1698	150073	1.0568	150135	0.8486
140176	1.0796	140239	1.2728	150019	1.0368	150074	1.2745	160001	1.1599
140177	1.0271	140240	1.1520	150020	1.0672	150075	1.1544	160002	1.2230
140178	0.9643	140241	0.9429	150021	1.3755	150076	1.0554	160003	1.0531
140179	1.1420	140242	1.2214	150022	1.0491	150077	1.1086	160004	1.1128
140180	1.1959	140243	1.1275	150023	1.1692	150078	1.0355	160005	1.1980
140181	1.0987	140245	1.0517	150024	1.1725	150079	1.0273	160007	1.0088
140182	1.1245	140246	1.0120	150025	1.1577	150081	1.0396	160008	1.1186
140184	0.9909	140247	1.0561	150026	1.1468	150082	1.3253	160009	1.0970
140185	1.1319	140248	1.1550	150027	1.0174	150083	1.1470	160012	1.1211
140186	1.0349	140249	0.7344	150029	1.1593	150084	1.5938	160013	1.2045
140187	1.1640	140250	1.1021	150030	1.0962	150085	0.9066	160014	0.9816
140188	0.9766	140251	1.0575	150031	0.9405	150086	1.0995	160016	1.2245
140189	1.0645	140252	1.1389	150032	1.6001	150088	1.0838	160018	1.0085
140190	0.9814	140253	1.1181	150033	1.1515	150089	1.1754	160020	0.9891
140191	1.1106	140258	1.2241	150034	1.0563	150090	1.1493	160021	1.1200
140192	1.0704	140261	1.0144	150035	1.1032	150091	1.0990	160023	1.0586
140193	0.9896	140271	0.9319	150036	0.9571	150092	1.0057	160024	1.2131
140197	1.1074	140273	0.9908	150037	1.1184	150094	0.9996	160025	1.5683
140199	0.9565	140275	1.0637	150038	1.1314	150095	1.0395	160026	1.0958
140200	1.2077	140276	1.8218	150039	1.0068	150096	1.0084	160027	1.1723
140202	1.1000	140280	1.1436	150042	1.1334	150097	1.0081	160028	1.1205
140203	1.0107	140281	1.2866	150043	1.0725	150098	0.9316	160029	1.2129
140204	1.2276	140285	1.0515	150044	1.0931	150099	1.1556	160030	1.2495
140205	1.0920	140286	1.1666	150045	1.0742	150100	1.1960	160031	1.0532
140206	0.9717	140288	1.1679	150046	1.1010	150101	1.0525	160032	1.0458
140207	1.1156	140289	1.2001	150047	1.2890	150102	1.1082	160033	1.2211
140208	1.2638	140290	1.1551	150048	1.1552	150103	0.9338	160034	0.9843

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
160035	0.8998	160089	1.1506	160151	1.1064	170053	0.9532	170110	0.9527
160036	1.1895	160090	1.0456	160152	0.9686	170054	0.9610	170112	1.0599
160037	1.1968	160091	1.0841	160153	1.4185	170055	1.0310	170113	0.9861
160038	1.1451	160092	1.0208	170001	1.1278	170056	0.9385	170114	1.0350
160039	1.0100	160093	0.9217	170002	1.1425	170057	0.9606	170115	0.9921
160040	1.1426	160094	1.0745	170003	1.1171	170058	1.0329	170116	1.0656
160041	1.0192	160095	0.9725	170004	0.9626	170060	1.0141	170117	1.0201
160043	1.1186	160097	1.1397	170005	0.9047	170061	1.0512	170119	0.8756
160044	1.1326	160098	1.0838	170006	1.0856	170062	0.9875	170120	1.0787
160045	1.3493	160099	0.9891	170007	1.0749	170063	1.0158	170121	0.8497
160046	1.1588	160101	1.0838	170008	0.9489	170064	0.9806	170122	1.5583
160047	1.2640	160102	1.2302	170009	1.0783	170066	0.9866	170123	1.2306
160048	1.0651	160103	0.9111	170010	1.0424	170067	0.9890	170124	0.9956
160049	1.0002	160104	1.1178	170011	1.1457	170068	1.1162	170125	0.9186
160050	1.0538	160106	1.1300	170012	1.2780	170069	1.0352	170126	0.8811
160051	1.1273	160107	1.1361	170013	1.1149	170070	0.9669	170128	0.9555
160052	1.1060	160108	1.1334	170014	1.0265	170072	0.9538	170130	1.0767
160053	1.1539	160109	1.0517	170015	1.0430	170073	1.1038	170131	1.0716
160054	1.0778	160110	1.3559	170016	1.3039	170074	1.0578	170133	1.0929
160055	1.0437	160111	1.1524	170017	1.0622	170075	0.9801	170134	0.9763
160056	1.0055	160112	1.2017	170018	1.0770	170076	1.0990	170137	1.1547
160057	1.1678	160113	1.0571	170019	1.1520	170077	0.9050	170138	1.0829
160058	1.4334	160114	0.9627	170020	1.1499	170079	0.8594	170139	0.9680
160059	1.2288	160115	1.0965	170021	0.9328	170080	0.9479	170140	1.0072
160060	1.0583	160116	1.0453	170022	1.0976	170081	1.0850	170142	1.0917
160061	1.0430	160117	1.2443	170023	1.2223	170082	0.9813	170143	1.0662
160062	1.0222	160118	1.0993	170024	1.0053	170084	0.9515	170144	1.2199
160063	1.0760	160119	0.9764	170025	1.1884	170085	0.9326	170145	1.0519
160064	1.1955	160120	0.9485	170026	1.0908	170086	1.2732	170146	1.2130
160065	1.0879	160122	1.1051	170027	1.0271	170087	1.1750	170147	1.1355
160066	1.0790	160123	1.0925	170030	0.9509	170088	0.9780	170148	1.1487
160067	1.1326	160124	1.0937	170031	1.0103	170089	0.8864	170150	1.0425
160068	1.1012	160126	1.0887	170032	0.9835	170090	0.9881	170151	1.0307
160069	1.2636	160129	1.1116	170033	1.0554	170091	0.9336	170152	0.9082
160070	1.0657	160130	1.1435	170034	0.9512	170092	1.0448	170159	1.0262
160071	1.1249	160131	1.0939	170035	0.9480	170093	0.9791	170160	0.9257
160072	1.1052	160132	1.0670	170036	0.9737	170094	1.0130	170164	1.0672
160073	0.9755	160133	1.0544	170037	1.1205	170095	1.0315	170166	0.9955
160074	0.9598	160134	0.9817	170038	0.9981	170097	1.0227	170168	0.9088
160075	1.0035	160135	1.0186	170039	1.0059	170098	1.0089	170170	1.0664
160076	1.0150	160136	1.0173	170040	1.2871	170099	1.0507	170171	1.0496
160077	1.0978	160138	1.1129	170041	0.9857	170100	0.8927	170172	1.0320
160079	1.2440	160139	0.8631	170043	0.9901	170101	0.9436	170173	0.9223
160080	1.1211	160140	1.0154	170044	1.0140	170102	1.0250	170174	0.9091
160081	1.1560	160141	1.0242	170045	0.9403	170103	1.1034	170175	1.0553
160082	1.4559	160142	1.1471	170046	0.9725	170104	1.2391	170176	1.2076
160083	1.3980	160143	1.0936	170049	1.1835	170105	1.1254	170177	0.9630
160085	1.1989	160145	1.0985	170050	0.9924	170106	0.9439	180001	1.0727
160086	0.9911	160146	1.2394	170051	0.9521	170108	0.9347	180002	0.9601
160088	1.0706	160147	1.1286	170052	0.9547	170109	0.9835	180004	1.0127

PROVIDER	CASE MIX
180005	1.0352
180006	0.8766
180007	1.0882
180009	1.0932
180010	1.3673
180011	0.9610
180012	1.1007
180013	1.1434
180014	1.3673
180015	0.9929
180016	1.0803
180017	1.0919
180018	1.0900
180019	1.0148
180020	0.9506
180021	0.9106
180023	0.8768
180024	0.9961
180025	1.0717
180026	1.0464
180027	0.9870
180028	0.8755
180029	1.0093
180030	0.9319
180031	0.9756
180032	0.9331
180033	1.0198
180034	1.0186
180035	1.1086
180036	1.0506
180037	1.1459
180038	1.0762
180040	1.3163
180041	0.9811
180042	1.0065
180043	0.9887
180044	0.9734
180045	1.1066
180046	1.0208
180047	1.0300
180048	1.0899
180049	1.0953
180050	0.9960
180051	1.1413
180053	0.9085
180054	1.1277
180055	1.0322
180056	1.0140
180058	0.8701
180059	0.9566
180060	0.8437
180062	0.9210
180063	0.9184
180064	1.0260
180065	0.9189
180066	1.0315
180067	1.4119
180069	0.9606
180070	0.9526
180072	1.0156
180075	0.9104
180078	0.9311
180079	0.9692
180080	0.9907
180081	1.0867
180085	1.1274
180087	1.0388
180088	1.3140
180092	1.0503
180093	1.1334
180094	0.9490
180095	1.0260
180099	0.9111
180100	1.1047
180101	1.0571
180102	1.1415
180103	1.3338
180104	1.1563
180105	0.8840
180106	0.8619
180108	0.8630
180114	0.8523
180115	1.0133
180116	1.0585
180117	0.9067
180118	1.0057
180120	0.9235
180121	0.9673
180122	0.9003
180123	1.1454
180124	1.0640
180125	0.9207
180126	0.8966
180127	1.0486
180128	1.0135
180129	0.9764
180130	1.1519
180132	1.1166
180133	1.0480
180134	1.0631
180136	1.0586
180137	1.2360
190001	0.9767
190002	1.2713
190003	1.0905
190004	1.0524
190005	1.1025
190006	1.0719
190007	0.9549
190008	1.1421
190009	1.0719
190010	1.0255
190011	1.0158
190012	0.9000
190013	1.0639
190014	0.9121
190015	1.0413
190016	1.0291
190017	1.1251
190018	1.0692
190019	1.2969
190020	1.0320
190023	0.9136
190025	1.0659
190026	1.1676
190027	1.1986
190029	1.1145
190033	0.9404
190034	1.0407
190035	1.1908
190036	1.4140
190037	0.9010
190039	1.2149
190040	1.0906
190041	1.2596
190043	1.0446
190044	1.0339
190045	1.0466
190046	1.2424
190047	0.9908
190048	1.0227
190049	1.0043
190050	0.9740
190053	1.0092
190054	1.0888
190058	0.9896
190059	1.0664
190060	1.0908
190064	1.1729
190065	1.2554
190067	1.0123
190071	0.9016
190073	0.9091
190075	1.1044
190077	0.9485
190078	1.0450
190079	1.1554
190081	0.8641
190083	0.9594
190086	1.0922
190088	0.9560
190089	0.9702
190090	0.9644
190092	1.1631
190095	0.9158
190098	1.2710
190099	0.9903
190101	0.9093
190102	1.2141
190103	0.8594
190106	1.0017
190109	1.0880
190110	0.9871
190111	1.2323
190112	1.1447
190113	1.0551
190114	0.8844
190115	1.1181
190116	1.0234
190117	1.0100
190118	0.9875
190119	0.8929
190120	0.9422
190122	1.1588
190124	1.1950
190125	1.1632
190127	1.0469
190128	0.8806
190130	0.9320
190131	0.9993
190132	1.0680
190133	0.9801
190134	0.8454
190135	1.2772
190136	0.9352
190137	0.9265
190138	0.6053
190139	1.0066
190140	1.0409
190141	0.8998
190142	0.9176
190144	1.0261
190145	1.0353
190146	1.2950
190147	0.9746
190148	0.9327
190149	0.9721
190151	1.0293
190152	1.0670
190155	1.0028
190156	0.9238
190157	0.9513
190158	1.0472
190160	0.9816
190161	1.0242
190162	1.1367
190163	0.9179
190164	1.0327
190165	0.9895
190166	0.9814
190167	0.9539
190169	0.9023
190170	0.9331
190173	1.1382
190175	1.0784
190176	1.3343
190177	0.9813
190178	0.9337
190179	0.9776
190180	1.0741
190182	0.9073
190183	1.0274
190184	0.9100
190185	1.0784
190186	0.8880
190187	1.2312
190188	0.9377
190190	0.8902
190191	1.1040
190193	1.0963
190194	0.9752
190195	0.9489
190197	1.2599
190198	1.0544
200001	1.2464
200002	0.9587
200003	1.0377
200005	0.8689
200006	0.9724
200007	1.0053

PROVIDER	CASE MIX
200008	1.1654
200009	1.4730
200012	1.0968
200013	1.1363
200015	1.2227
200016	1.0646
200017	1.1068
200018	1.0992
200019	1.1933
200020	1.0376
200021	1.1471
200023	0.9980
200024	1.1539
200025	1.1206
200026	1.0098
200027	1.0769
200028	0.9572
200031	1.1659
200032	1.1876
200033	1.3107
200034	1.1108
200037	1.1281
200038	0.9886
200039	1.1942
200040	1.0738
200041	1.0060
200043	0.9642
200044	1.1333
200047	1.1118
200049	0.9467
200050	1.0389
200051	0.9949
200052	1.0404
200055	1.0083
200058	0.8939
200062	1.0325
200063	1.1974
200066	1.1629
210001	1.2074
210002	1.3525
210003	1.1621
210004	1.1578
210005	1.1849
210006	1.0725
210007	1.2888
210008	1.1261
210009	1.2618
210010	1.0644
210011	1.2000
210012	1.1174
210013	1.1604
210015	1.1477
210016	1.3442
210017	1.0817
210018	1.1857
210019	1.2122
210021	1.0614
210022	1.1374
210023	1.1711
210024	1.1871
210025	1.0696
210026	1.1708
210027	1.1197
210028	1.0280
210029	1.1902
210030	1.0317
210031	1.4205
210032	1.0440
210033	1.1082
210034	1.1055
210035	1.0964
210037	1.1247
210038	1.0447
210039	1.1196
210040	1.1929
210041	1.0791
210042	1.1419
210043	1.0823
210044	1.0870
210045	1.0359
210046	1.0060
210047	0.9359
210048	1.0605
210049	1.1136
210050	1.0451
210051	1.1878
210054	1.1216
210055	1.1325
210056	1.2602
210057	1.1920
210058	1.3966
220001	1.1172
220002	1.2555
220003	0.9894
220004	1.1354
220005	1.0448
220006	1.0959
220008	1.0820
220009	1.0715
220010	1.0829
220011	1.1044
220012	1.1907
220015	1.1067
220016	1.1007
220017	1.0979
220019	1.0905
220020	1.0929
220021	1.1477
220022	1.0841
220023	1.1061
220024	1.1523
220025	1.0841
220026	1.1509
220028	1.0873
220029	1.0609
220030	1.0774
220031	1.2929
220033	1.0941
220034	1.0354
220035	1.0943
220036	1.1966
220038	1.0497
220040	1.0810
220041	1.1249
220042	1.0626
220045	1.1170
220046	1.2069
220048	1.1090
220049	1.0912
220050	1.0031
220051	1.0955
220052	1.0977
220053	1.1133
220055	1.1136
220057	1.0910
220058	1.0671
220060	1.0850
220061	1.0535
220062	0.4326
220063	1.1202
220064	1.0925
220065	1.0830
220066	1.1589
220067	1.1723
220068	0.9057
220069	0.9462
220070	1.1583
220071	1.3765
220072	0.9808
220073	1.1468
220074	1.0319
220075	0.6927
220076	1.0737
220077	1.2346
220079	1.0691
220080	1.0830
220081	0.9834
220082	1.1147
220083	1.0901
220084	1.0877
220086	1.3543
220087	0.8797
220088	1.2734
220089	1.1164
220090	1.0418
220092	1.0846
220094	1.0537
220095	1.0288
220097	1.0522
220098	1.0874
220099	1.0485
220100	1.2032
220101	1.1365
220102	0.8878
220104	1.0168
220105	1.0540
220106	1.0769
220107	0.9954
220108	1.0583
220110	1.5701
220111	1.1063
220114	1.0203
220115	1.0982
220116	1.3951
220117	0.9660
220118	1.3789
220119	1.1609
220120	0.9807
220121	1.0771
220123	1.0409
220126	1.1331
220128	1.0427
220129	1.0996
220131	1.0117
220133	0.8283
220135	1.1373
220153	1.0156
220154	1.0268
220156	1.0819
220163	1.3609
220171	1.2997
230001	1.0227
230002	1.1073
230003	1.0869
230004	1.3238
230005	1.0749
230006	1.0389
230007	1.0336
230008	0.9458
230011	1.0616
230012	1.0397
230013	1.1543
230014	1.0721
230015	1.0842
230017	1.2403
230019	1.1794
230020	1.1721
230021	1.1993
230022	1.1277
230024	1.3246
230027	1.0087
230029	1.1513
230030	1.0770
230031	1.1955
230032	1.4376
230034	1.0514
230035	0.9774
230036	1.1353
230037	1.0488
230038	1.5022
230039	1.1422
230040	1.1024
230041	1.0751
230042	1.0413
230043	0.8970
230046	1.4574
230047	1.0894
230051	1.0091
230053	1.2540
230054	1.3267
230055	1.0335
230056	0.9570
230057	1.0115
230058	1.0461
230059	1.2339
230060	1.0518
230062	1.0326
230063	1.1334
230065	1.0957
230066	1.1044

PROVIDER	CASE MIX
230067	0.9845
230068	1.2024
230069	1.1052
230070	1.2034
230071	0.7198
230072	1.0858
230075	1.1036
230076	1.1660
230077	1.4433
230078	1.0194
230080	1.0590
230081	1.0200
230082	0.9378
230084	1.0356
230085	1.0774
230086	1.0285
230087	1.0326
230089	1.1090
230090	1.1218
230092	1.1241
230093	1.0584
230095	1.0210
230096	1.0023
230097	1.1513
230098	1.1332
230099	1.0587
230100	1.0163
230101	1.0711
230102	1.2573
230103	1.0443
230104	1.1793
230105	1.3155
230106	1.0198
230107	1.0072
230108	1.1257
230110	1.1213
230111	0.9143
230113	0.8472
230114	0.8619
230115	1.0609
230116	0.9057
230117	1.5946
230118	1.1049
230119	1.0316
230120	0.9747
230121	1.0085
230122	1.1688
230123	0.8555
230124	1.0573
230125	1.2206
230128	1.1074
230129	1.3957
230130	1.2653
230132	1.1500
230133	1.1218
230134	0.9452
230135	1.0681
230137	1.0559
230138	0.8748
230139	1.0084
230140	1.0186
230141	1.2853
230142	1.0372
230143	1.2154
230144	1.0334
230145	1.0704
230146	1.1345
230147	1.0554
230149	0.9898
230150	1.3530
230151	1.2308
230153	1.0630
230154	0.9522
230155	0.9534
230156	1.3099
230157	1.0993
230158	0.9762
230159	1.1071
230161	0.8665
230162	0.8742
230163	1.0220
230165	1.2481
230167	1.1199
230169	1.0866
230171	1.0010
230172	1.0880
230173	1.0997
230174	1.1179
230175	0.9634
230176	1.0988
230177	0.8848
230178	1.0110
230179	0.9130
230180	0.9926
230181	1.0077
230183	1.0895
230184	1.0214
230186	0.9862
230188	0.9949
230189	0.9011
230190	1.0857
230191	0.8943
230193	1.0791
230194	1.0306
230195	1.1582
230197	1.0847
230199	1.0574
230201	0.9459
230203	0.9856
230204	1.2062
230205	1.0760
230207	1.0408
230208	1.0117
230211	0.9079
230212	1.0438
230213	0.9326
230216	1.1669
230217	1.0396
230219	0.8888
230221	1.0850
230222	1.1198
230223	1.1441
230224	0.9547
230225	0.9526
230227	1.0851
230228	1.1435
230230	1.1432
230231	0.9972
230232	0.9099
230235	0.9231
230236	1.1832
230237	1.1550
230238	0.9464
230239	1.0025
230241	0.9920
230244	1.1076
230253	1.0094
230254	1.0904
230256	1.0046
230257	0.9527
230258	1.0231
230259	0.9772
230264	0.8595
230265	1.0711
230266	1.0465
230269	1.1034
230270	1.1051
230272	0.9486
230273	1.1323
230276	1.3689
240001	1.2583
240002	1.3839
240003	1.1686
240004	1.2979
240005	1.0825
240006	1.1123
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240008	1.0409
240009	1.0693
240010	1.7230
240011	1.0227
240013	1.1221
240014	1.1274
240016	1.0830
240017	1.1200
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240019	1.3786
240020	1.0506
240021	1.0932
240022	1.0720
240023	1.0418
240024	1.1896
240025	1.0965
240026	1.2566
240027	1.0205
240028	1.0669
240029	1.0504
240030	1.2834
240031	0.8833
240033	0.9592
240036	1.2286
240037	1.0737
240038	1.2988
240040	1.1383
240041	1.0540
240043	1.1754
240044	1.1084
240045	1.0511
240046	1.2762
240047	1.2429
240048	1.1554
240049	1.3577
240050	1.1462
240051	1.0553
240052	1.1946
240053	1.2586
240054	1.1155
240055	1.1774
240056	1.2389
240057	1.5244
240058	1.0560
240059	1.0763
240061	1.3818
240062	1.0761
240063	1.2414
240064	1.1593
240065	0.9139
240066	1.1698
240069	1.0152
240071	1.0872
240072	0.9834
240073	0.9856
240074	1.1062
240075	1.1606
240076	1.0858
240077	0.9747
240078	1.2189
240079	0.9938
240080	1.2310
240081	1.2322
240082	1.1548
240083	1.1606
240084	1.2193
240085	0.9627
240086	1.0800
240087	1.1061
240088	1.3329
240089	0.9601
240090	1.1406
240091	1.0974
240093	1.2336
240094	1.0031
240096	1.0144
240097	1.1944
240098	1.0388
240099	1.1003
240100	1.1392
240101	1.0253
240102	1.0057
240103	1.0698
240104	1.1842
240105	0.9566
240106	1.2248
240107	1.0008
240108	1.1200
240109	1.0347
240110	1.0894
240111	1.0572
240112	0.9721
240114	1.0281

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
240115	1.1934	240173	0.9875	250036	0.9544	250097	1.0163	260015	1.0228
240116	1.0018	240175	1.0324	250037	0.9092	250098	0.8478	260016	1.1201
240117	1.0732	240176	1.1171	250038	0.8677	250099	1.0417	260017	1.1365
240118	0.9460	240177	0.9266	250039	1.0063	250100	1.1286	260018	0.9210
240119	0.9641	240179	1.0020	250040	1.0800	250101	0.9116	260019	1.0610
240121	0.9605	240180	1.1370	250041	0.9223	250102	1.3066	260020	1.2641
240122	0.9612	240183	1.0230	250042	1.0046	250104	0.9882	260021	1.2241
240123	1.0279	240184	1.1424	250043	0.8729	250105	0.9280	260022	1.1471
240124	1.0166	240187	1.1877	250044	0.9735	250106	0.8386	260023	1.0347
240125	1.0026	240192	0.8591	250045	0.9533	250107	0.9417	260024	1.0613
240127	1.1144	240193	1.0881	250046	0.9596	250109	0.9069	260025	1.0836
240128	1.1510	240194	0.9938	250047	0.9058	250110	0.9585	260026	1.0464
240129	1.0217	240195	1.0402	250048	1.2455	250111	0.9156	260027	1.2696
240130	1.0209	240196	1.3616	250049	0.9126	250112	0.8454	260029	1.0711
240131	1.2004	240200	0.9880	250050	1.1179	250113	0.9166	260030	1.0421
240132	1.1706	240201	0.9742	250051	0.8155	250114	0.8932	260031	1.2782
240133	1.1217	240205	0.8795	250057	1.0193	250116	0.8537	260032	1.3977
240134	1.1784	240206	0.9092	250058	1.0496	250117	0.9426	260033	1.1840
240135	0.9721	240207	1.1641	250059	1.0069	250118	1.0027	260034	1.0123
240136	1.0471	250001	1.3109	250060	0.8656	250119	0.8874	260035	0.9623
240137	1.0354	250002	0.8722	250061	0.9717	250120	1.0902	260036	1.0112
240138	1.0691	250003	0.8704	250062	0.9289	250121	0.9379	260037	1.0828
240139	1.0832	250004	1.1912	250063	0.8617	250122	1.0174	260039	1.0551
240140	0.9510	250005	0.9535	250065	0.9135	250123	1.1043	260040	1.2261
240141	1.0003	250006	0.9164	250066	0.9045	250124	0.8824	260041	1.0508
240142	1.0926	250007	1.0033	250067	1.0535	250125	1.0784	260042	0.9432
240143	1.0227	250008	0.9101	250068	0.8875	250126	0.9778	260044	1.0262
240144	1.1253	250009	1.0953	250069	1.0763	250127	0.8737	260045	1.0804
240145	1.0539	250010	0.9016	250071	0.9500	250128	0.9801	260047	1.0713
240146	1.0426	250012	0.9531	250072	1.0907	250129	0.9689	260048	1.1480
240148	1.0163	250014	1.0155	250073	0.9422	250130	0.8708	260049	0.9307
240150	0.8978	250015	0.9894	250075	0.9686	250131	0.9966	260050	0.9779
240152	0.9517	250016	0.8436	250076	0.8891	250132	1.0345	260051	1.1496
240153	1.0218	250017	0.9044	250077	0.9150	250133	0.8490	260052	1.0858
240154	0.9781	250018	0.9810	250078	1.1069	250134	1.0597	260053	1.0835
240155	1.0447	250019	1.1037	250079	0.8405	250137	0.8457	260054	1.2043
240156	1.0555	250020	0.9202	250080	0.9290	260001	1.3164	260055	0.9586
240157	0.9596	250021	0.9796	250081	1.0809	260002	1.1388	260056	1.0567
240158	1.0537	250023	0.8600	250082	1.1666	260003	0.9685	260057	1.0791
240160	1.0263	250024	0.9190	250083	0.8604	260004	0.9695	260058	1.2059
240161	0.9637	250025	0.9780	250084	1.0352	260005	1.1289	260059	1.0407
240162	1.1787	250026	0.8215	250085	0.9838	260006	1.1218	260061	1.0424
240163	1.0935	250027	0.9459	250086	0.9982	260007	1.0435	260062	1.0999
240165	1.1410	250029	0.9335	250088	1.0069	260008	1.1416	260063	1.0366
240166	1.0533	250030	0.8904	250089	0.9825	260009	1.0976	260064	1.1079
240167	0.9642	250031	1.0195	250091	0.9167	260010	1.0986	260065	1.2953
240169	0.9669	250032	1.0855	250093	1.0354	260011	1.1132	260066	1.0086
240170	1.0247	250033	0.9098	250094	1.0968	260012	0.9265	260067	0.9755
240171	1.0785	250034	1.0439	250095	0.9140	260013	1.0305	260068	1.5062
240172	1.0590	250035	0.8570	250096	1.0112	260014	1.3548	260070	0.9880

PROVIDER	CASE MIX
260073	0.9719
260074	1.0759
260077	1.1543
260078	1.0149
260079	0.9827
260080	0.9753
260081	1.1890
260082	1.0917
260083	0.9655
260084	0.8855
260085	1.1821
260086	1.0002
260088	0.9856
260089	1.1296
260090	1.2300
260091	1.2347
260092	1.0167
260093	1.1825
260094	1.0410
260095	1.1118
260096	1.2155
260097	1.0847
260100	1.1414
260102	0.9175
260103	1.1739
260104	1.2537
260105	1.6420
260107	1.1259
260108	1.3769
260109	0.8979
260110	1.1351
260111	0.9433
260112	1.1934
260113	1.0582
260115	0.9903
260116	1.1167
260118	1.1862
260119	1.0357
260120	1.0649
260121	0.9354
260122	1.0365
260123	0.9329
260127	0.9965
260128	0.8987
260129	1.1094
260131	1.1655
260133	1.0648
260134	1.0692
260137	1.0663
260138	1.6365
260141	1.5111
260142	1.1077
260143	1.1266
260146	0.9470
260147	1.0623
260148	0.9615
260150	1.0752
260158	1.0337
260159	0.9455
260160	1.0342
260162	1.1158
260163	1.1359
260164	1.0437
260165	1.0751
260166	1.1282
260168	0.8643
260172	0.9588
260173	1.1534
260175	1.0299
260176	1.1488
260177	1.1871
260178	1.1245
260179	1.2392
260180	1.2351
260182	0.9945
260183	1.1041
260184	0.7000
260186	1.0680
260187	0.7503
260188	1.0944
260189	0.9883
260190	1.1140
260191	1.1434
260192	0.7579
260193	1.0904
260195	0.9789
260197	1.0624
270001	0.9366
270002	0.9968
270003	1.1069
270004	1.5502
270006	1.0011
270007	0.8993
270008	0.8790
270009	0.9492
270011	1.0293
270012	1.2492
270013	1.1774
270014	1.4849
270016	0.9526
270017	1.2006
270018	1.0372
270019	0.9066
270021	1.0106
270023	1.1915
270024	0.9667
270026	0.8872
270027	1.0353
270028	1.0369
270029	0.9418
270030	0.8730
270031	0.8643
270032	1.0757
270033	0.8986
270035	0.9848
270036	1.0864
270039	0.8956
270040	1.0763
270041	0.9507
270042	0.7693
270043	0.7715
270044	0.9848
270046	0.9169
270047	0.8734
270048	0.9841
270049	1.3145
270050	0.9779
270051	1.1231
270052	0.9289
270053	0.9051
270055	0.7565
270057	1.1081
270058	0.9692
270059	0.8700
270060	0.8784
270063	0.9716
270067	0.9901
270068	0.9428
270070	0.9498
270071	0.9145
270072	0.8684
270073	0.9147
270074	0.8263
270075	0.8906
270076	0.9803
270079	0.8989
270080	1.0730
270081	0.9836
270082	0.9328
280001	1.0144
280003	1.4838
280004	1.0625
280005	1.2148
280009	1.2069
280010	1.1158
280011	0.9278
280012	1.0897
280013	1.3700
280014	0.9886
280015	0.8784
280017	1.0019
280018	0.9866
280020	1.1491
280021	1.1839
280022	1.0410
280023	1.1477
280024	0.8610
280025	0.9141
280026	0.9458
280028	0.9150
280029	0.9463
280030	1.3458
280031	0.9848
280032	1.1558
280033	0.9490
280034	1.1351
280035	0.9255
280037	1.0923
280038	1.0908
280039	0.9917
280040	1.3066
280041	0.9178
280042	1.0283
280043	0.9770
280045	1.0449
280046	0.9779
280047	1.0847
280048	1.0480
280049	0.9381
280050	0.9907
280051	1.0047
280052	1.0335
280054	1.0873
280055	0.9555
280056	1.0636
280057	0.9401
280058	1.0662
280060	1.1127
280061	1.2057
280062	1.0533
280063	0.6961
280064	0.9770
280065	1.0984
280066	1.0589
280068	0.9507
280070	0.9864
280071	0.9482
280073	1.0057
280074	1.0597
280075	1.1309
280076	1.0025
280077	1.1183
280078	0.9398
280079	0.9561
280080	0.9451
280081	1.1748
280082	0.9385
280083	1.0552
280084	0.9677
280085	1.1627
280087	1.1650
280088	1.2670
280089	0.9640
280090	0.8989
280091	1.1221
280092	0.8891
280093	0.8808
280094	0.9505
280097	0.9486
280098	0.8964
280101	0.9794
280102	0.9937
280103	0.9100
280104	0.9528
280105	1.0846
280106	0.9512
280107	1.0590
280108	1.0712
280109	1.0006
280110	1.0033
280111	1.0522
280114	0.9655
280115	0.9880
280116	1.1172
280117	1.0148
280118	1.0169
280123	0.6829
290001	1.3645
290002	0.9421
290003	1.3114

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
290005	1.0750	310005	1.1670	310061	1.1360	320013	0.9849	330013	1.3792
290006	0.9930	310006	1.1551	310062	0.9875	320014	0.9003	330014	1.1268
290007	1.3151	310008	1.1437	310063	1.1919	320016	1.0212	330015	0.9929
290008	1.1513	310009	1.0739	310064	1.0771	320017	1.1293	330016	0.9999
290009	1.2355	310010	1.1398	310067	1.1334	320018	1.1573	330019	1.0048
290010	1.0029	310011	1.1288	310068	1.1445	320019	1.2683	330020	0.9973
290011	0.9567	310012	1.1569	310069	1.1069	320021	1.5032	330022	0.9946
290012	1.2213	310013	1.1366	310070	1.1285	320022	1.1092	330023	1.0957
290013	1.2795	310014	1.2219	310071	1.0169	320023	1.0070	330024	1.3078
290014	0.9605	310015	1.1892	310072	1.1083	320030	1.0533	330025	0.9790
290015	0.9219	310016	1.1656	310073	1.1321	320031	0.9198	330027	1.0683
290016	1.0785	310017	1.0916	310074	1.1470	320032	0.9330	330028	1.1060
290018	0.8642	310018	1.0000	310075	1.1535	320033	1.1209	330029	1.1270
290019	1.1699	310019	1.3325	310076	1.1141	320035	0.9992	330030	0.9583
290020	1.0174	310020	1.1056	310077	1.2172	320037	1.1973	330033	1.0977
290021	1.3343	310021	1.1180	310078	1.1323	320038	1.1108	330034	1.0685
290022	1.3141	310022	1.1160	310081	1.1910	320046	1.0284	330036	1.0250
290027	1.0769	310024	1.1206	310083	1.0438	320048	1.0821	330037	1.0818
290031	1.0525	310025	1.0610	310084	1.1481	320049	1.0736	330038	1.0622
290032	1.1823	310026	1.1062	310085	1.0410	320051	0.9398	330039	0.9827
300001	1.1713	310027	1.1365	310086	1.0663	320053	0.9903	330041	1.0663
300002	1.1117	310028	1.0370	310087	1.1086	320056	0.8668	330043	1.0497
300003	1.4699	310029	1.4282	310088	1.0522	320057	1.0181	330044	1.0975
300005	1.1461	310031	2.1826	310090	1.0919	320058	0.8656	330045	1.1194
300006	1.0534	310032	1.0868	310091	1.1480	320059	1.1423	330047	1.1108
300007	1.0623	310033	1.0139	310092	1.1689	320060	0.9177	330048	1.0327
300008	1.1046	310034	1.1232	310093	0.9921	320061	1.1340	330049	1.0919
300009	1.0853	310036	1.0752	310094	0.9738	320062	0.9063	330050	1.0013
300010	1.0971	310037	1.1447	310096	1.2723	320063	1.1191	330052	1.0434
300011	1.0901	310038	1.2836	310105	1.0190	320065	1.0819	330053	0.9985
300012	1.1438	310039	1.1406	310108	1.1349	320066	0.9269	330055	1.1054
300013	1.0849	310040	1.0604	310110	1.1346	320067	0.8971	330056	1.1211
300014	1.1171	310041	1.1598	310111	1.0362	320068	1.0026	330057	1.1974
300015	1.0165	310042	1.0589	310112	1.1135	320069	1.0392	330058	1.0993
300016	1.0968	310043	1.0722	310113	1.0658	320070	0.9549	330059	1.2166
300017	1.1167	310044	1.1132	310115	1.0567	320071	0.9432	330061	1.0576
300018	1.1426	310045	1.1030	310116	1.1538	320073	0.9191	330062	0.9795
300019	1.0886	310047	1.2207	310118	1.0514	320074	1.1807	330064	1.1407
300020	1.1150	310048	1.1730	310119	1.1696	330001	1.1023	330065	1.0195
300021	1.0932	310049	1.0726	310120	1.0308	330002	1.0890	330066	1.0512
300022	1.0504	310050	0.9497	320001	1.2699	330003	1.1376	330067	1.1155
300023	1.1544	310051	1.1809	320002	1.1867	330004	1.0625	330072	1.1073
300024	1.1262	310052	1.1370	320003	1.0887	330005	1.2890	330073	1.0299
300028	1.0631	310053	1.1572	320004	1.1162	330006	1.1862	330074	1.0937
300029	1.1787	310054	1.2116	320005	1.2321	330007	1.1309	330075	0.9633
300033	0.9570	310056	1.1124	320006	1.1500	330008	1.0435	330076	1.0316
300034	1.1309	310057	1.2082	320009	1.1996	330009	0.9077	330077	0.9378
310001	1.1430	310058	0.9877	320010	1.1100	330010	1.0343	330078	1.1709
310002	1.4603	310059	0.9311	320011	1.0375	330011	1.0903	330079	1.1413
310003	1.0878	310060	1.1236	320012	0.9141	330012	1.1928	330080	1.0056

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
330082	1.0584	330157	1.0345	330217	1.0154	330286	1.1169	340006	1.0162
330084	1.0104	330158	1.0963	330218	1.0326	330288	0.9595	340007	1.0383
330085	1.2206	330159	1.1658	330219	1.1593	330290	1.1813	340008	1.0381
330086	1.0397	330160	1.0486	330221	1.0820	330291	1.0137	340009	0.7467
330088	1.0995	330161	1.0430	330222	1.0129	330293	0.9598	340010	1.0941
330090	1.2808	330162	1.1307	330223	0.9225	330297	1.0327	340011	1.0040
330091	1.1191	330163	1.0077	330224	1.0650	330300	0.8785	340012	1.0533
330092	0.9912	330164	1.2684	330225	1.0299	330304	1.1147	340013	1.1348
330094	1.1029	330165	1.0362	330226	1.0878	330306	1.1809	340014	1.2508
330095	1.0676	330166	0.9842	330229	1.0706	330307	1.0284	340015	1.1000
330096	0.9634	330167	1.1917	330230	1.0524	330308	1.0820	340016	1.0673
330097	1.0057	330168	1.0565	330231	1.0177	330309	1.0927	340017	1.1280
330100	0.6152	330169	1.0679	330232	1.0942	330314	1.0902	340018	1.2401
330101	1.2670	330171	1.1088	330233	1.0374	330315	1.0637	340019	1.0806
330102	1.1591	330172	1.0031	330234	1.4320	330316	1.1382	340020	1.1064
330103	1.0935	330174	0.9521	330235	1.1029	330318	1.0306	340021	1.1748
330104	1.0909	330175	1.0345	330236	1.1607	330320	1.0422	340022	1.0314
330106	1.3214	330176	0.8667	330238	1.0305	330323	1.0080	340023	1.1403
330107	1.0929	330177	0.9881	330239	1.0512	330327	0.9158	340024	1.0288
330108	1.0657	330179	0.9306	330240	0.9827	330331	1.0531	340025	1.0769
330109	0.9739	330180	1.0532	330241	1.4642	330332	1.0440	340026	0.9227
330111	1.0606	330181	1.1301	330242	1.0862	330333	0.9756	340027	1.0556
330114	0.9111	330182	1.8728	330244	1.0561	330335	1.0479	340028	1.1566
330115	1.0372	330183	1.2758	330245	1.1106	330336	1.0394	340030	1.5298
330116	0.9706	330184	1.1168	330246	1.0768	330338	1.0116	340031	1.0626
330117	1.0792	330185	1.0487	330247	0.6034	330339	0.9272	340032	1.2081
330118	1.1712	330186	1.0174	330249	1.0606	330340	0.9399	340034	1.2568
330119	1.1162	330188	1.0773	330250	1.0289	330345	0.8731	340035	1.1706
330120	1.2980	330189	0.6567	330252	0.9233	330350	1.4834	340036	0.9997
330121	1.0078	330191	1.0776	330254	1.0080	330351	0.9430	340037	1.0503
330122	1.0692	330193	1.1435	330256	0.9260	330353	1.0586	340038	1.1499
330125	1.3985	330194	1.2452	330257	0.8967	330354	0.8575	340039	1.0989
330126	1.0456	330195	1.2200	330258	1.0905	330357	1.0763	340040	1.3596
330127	1.0522	330196	1.1286	330259	1.0845	330359	0.9848	340041	1.1690
330128	1.1053	330197	1.0031	330260	1.1125	330372	1.0743	340042	1.0530
330132	0.9992	330198	1.0838	330261	1.1233	330381	0.9661	340044	1.0106
330133	1.0492	330199	1.0327	330263	0.9756	330385	1.0156	340045	1.0512
330135	1.0290	330201	1.0494	330264	1.0493	330386	1.0406	340047	1.4635
330136	1.2150	330202	1.0384	330265	1.1398	330387	0.8696	340049	0.6490
330140	1.2303	330203	1.1593	330267	1.0869	330389	1.4015	340050	1.0989
330141	1.1054	330204	1.0616	330268	1.0276	330390	1.0186	340051	1.0852
330142	1.0691	330205	1.0656	330270	1.5459	330393	1.2231	340052	0.9694
330144	0.9954	330208	1.0462	330272	0.9012	330394	1.0582	340053	1.1612
330148	0.9741	330209	1.0260	330273	1.0646	330395	1.0841	340054	0.9705
330150	0.9339	330210	0.9763	330275	1.1382	330397	1.1226	340055	1.1044
330151	1.0175	330211	0.9804	330276	1.1298	340001	1.1169	340060	1.0407
330152	1.0725	330212	0.9861	330277	1.0073	340002	1.4251	340061	1.3961
330153	1.1293	330213	0.9572	330279	1.0886	340003	1.1066	340063	1.0657
330154	1.2593	330214	1.3554	330281	0.9326	340004	1.2509	340064	1.0535
330155	1.0185	330215	1.0738	330285	1.3557	340005	1.1281	340065	1.0507

PROVIDER	CASE MIX
340067	0.9648
340068	1.0287
340069	1.4173
340070	1.2512
340071	0.9862
340072	0.9613
340073	1.0743
340075	1.0941
340076	1.0046
340079	0.9465
340080	1.0200
340084	1.0420
340085	1.1505
340086	1.0003
340087	0.9819
340088	1.0900
340089	1.0236
340090	1.0955
340091	1.4021
340093	1.0957
340094	1.1339
340096	1.1175
340097	0.9730
340098	1.3576
340099	1.0713
340100	1.1520
340101	1.0785
340104	0.9558
340105	1.1801
340106	0.9642
340107	1.2187
340109	1.2690
340111	1.1446
340112	1.0296
340113	1.5986
340114	1.1151
340115	1.2305
340116	1.3683
340119	1.1107
340120	1.0322
340121	1.0563
340122	0.9860
340123	1.0816
340124	0.9186
340125	1.2621
340126	1.1685
340127	1.1511
340129	1.0833
340130	1.1246
340131	1.2484
340132	1.0965
340133	0.9435
340135	0.9963
340136	1.0031
340137	0.9700
340138	1.1110
340141	1.2117
340142	1.1645
340143	1.1785
340144	1.0300
340145	1.0409
340146	1.0126
340147	1.2187
340148	1.0923
340151	1.0446
340153	1.7592
340154	0.8515
340155	1.2507
340156	0.8375
340157	1.0966
340158	1.0159
340159	1.0760
340160	0.9734
340162	1.0570
340164	1.1183
340165	0.9228
350001	0.9679
350002	1.3149
350003	1.0719
350004	1.4420
350005	1.2482
350006	1.0986
350007	0.9798
350008	0.8827
350009	1.0873
350010	1.0400
350011	1.5418
350012	0.9944
350013	0.9972
350014	0.9554
350015	1.3903
350016	1.0665
350017	1.0746
350018	1.0253
350019	1.2615
350020	1.2122
350021	0.9962
350023	0.9977
350024	0.9512
350025	0.9411
350027	0.9583
350029	0.9241
350030	1.0262
350031	1.0127
350032	1.0522
350033	0.8982
350034	0.9891
350035	0.8736
350036	1.0365
350037	0.9839
350038	0.9086
350039	0.9596
350041	0.9751
350042	1.0736
350043	1.1320
350044	0.9030
350045	0.9397
350047	0.9862
350048	0.9935
350049	1.0230
350050	0.8763
350051	0.9394
350053	0.9354
350055	0.8563
350056	0.9178
350058	0.9458
350060	0.9419
350061	1.0115
350063	0.9165
350064	0.9102
360001	1.1209
360002	1.0678
360003	1.2274
360006	1.3414
360007	1.0374
360008	1.1007
360009	1.1504
360010	1.0888
360011	1.1561
360012	1.1586
360013	1.1402
360014	1.0352
360015	1.2668
360016	1.1809
360017	1.2418
360018	1.0927
360019	1.1445
360020	1.1154
360021	1.0999
360022	1.0646
360024	1.0469
360025	1.0540
360026	1.1280
360027	1.3161
360028	1.1232
360029	1.0176
360030	1.0861
360031	1.1679
360032	1.0825
360034	1.0941
360035	1.3074
360036	1.0863
360037	1.4138
360038	1.1264
360039	1.1234
360040	1.1259
360041	1.1424
360042	1.0093
360044	1.0956
360045	1.2089
360046	0.9760
360047	0.9791
360048	1.3123
360049	1.1424
360050	1.1257
360051	1.2267
360052	1.1439
360053	1.1741
360054	1.1359
360055	1.1482
360056	1.1106
360057	1.0153
360058	1.0779
360059	1.1978
360060	0.9953
360061	0.6691
360062	1.2534
360063	1.0062
360064	1.2256
360065	1.1850
360066	1.1214
360067	1.0523
360068	1.2810
360069	1.0196
360070	1.1179
360071	1.1065
360072	1.1303
360074	1.1452
360075	1.1435
360076	1.0822
360077	1.1896
360078	1.0588
360079	1.1716
360080	1.0778
360081	1.0678
360082	1.2063
360083	1.0561
360084	1.1761
360085	1.3897
360086	1.1129
360087	1.2022
360088	1.0518
360089	1.1177
360090	1.0885
360091	1.1901
360092	1.0347
360093	1.0388
360094	1.0593
360095	1.1411
360096	1.1079
360097	1.0662
360098	1.1636
360099	1.0469
360100	1.1119
360101	1.3103
360102	1.2007
360103	1.1352
360104	1.0952
360106	1.1702
360107	1.0780
360108	1.0878
360109	1.0530
360110	0.7645
360112	1.3225
360113	1.1253
360114	1.0098
360115	1.0613
360116	1.0587
360118	1.1432
360119	1.0601
360120	0.9968
360121	1.2026
360122	1.1211
360123	1.1120
360124	1.1211
360125	1.0636
360126	1.0674
360127	1.0012
360128	1.0402
360129	0.9792

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
360130	1.0424	360189	1.0379	370034	1.0729	370103	0.9199	370180	1.1021
360131	1.1132	360190	1.0154	370035	1.3072	370105	1.7274	370182	0.9764
360132	1.0309	360192	1.1737	370036	0.9845	370106	1.1544	370183	1.0487
360133	1.1833	360193	1.1462	370037	1.5367	370107	1.0142	370184	1.2432
360134	1.2194	360194	1.0798	370038	0.9729	370108	1.0399	380001	1.2392
360135	1.0099	360195	1.0413	370039	1.1235	370109	0.8777	380002	1.1949
360136	1.0256	360197	1.0362	370040	1.0704	370110	0.9918	380003	1.1477
360137	1.2914	360200	1.0757	370041	0.9551	370112	0.9875	380004	1.5855
360139	1.0034	360203	1.0440	370042	0.8828	370113	0.9939	380005	1.0963
360140	1.0346	360204	1.1084	370043	0.9375	370114	1.4056	380006	1.0698
360141	1.1801	360210	1.0623	370045	1.0764	370116	0.9977	380007	1.4003
360142	1.0443	360211	1.0174	370046	0.9980	370117	1.0877	380008	1.1058
360143	1.1395	360212	1.1898	370047	1.0859	370121	1.1603	380009	1.3816
360144	1.1299	360213	1.1340	370048	0.9878	370122	0.9271	380010	1.1158
360145	1.2213	360218	1.1528	370049	1.1436	370123	1.1551	380011	1.0638
360147	1.0057	360230	1.1444	370050	0.9257	370125	0.9602	380013	1.0335
360148	1.1310	360231	1.0008	370051	1.0452	370126	1.1566	380014	1.1773
360149	1.0426	360232	1.1580	370054	1.1209	370130	0.9657	380016	0.8491
360150	1.1415	360234	1.1144	370056	1.1726	370131	0.9042	380017	1.4458
360151	1.1409	360236	1.1309	370057	1.1435	370133	1.0124	380018	1.4273
360152	1.1861	360238	1.3399	370059	1.1069	370136	1.0623	380019	1.1295
360153	1.0554	360239	1.0836	370060	1.0163	370138	1.0167	380020	1.1868
360154	1.0366	370001	1.4230	370061	0.9760	370139	1.0475	380021	1.1892
360155	1.0778	370002	1.0157	370063	1.1079	370140	0.9783	380022	1.1162
360156	1.0506	370003	1.0241	370064	0.9810	370141	1.1814	380023	1.1234
360159	1.0842	370004	1.0244	370065	1.0427	370144	1.1847	380024	1.1191
360161	1.0345	370005	0.9411	370069	0.8840	370146	1.0241	380025	1.2039
360162	1.0651	370006	1.1118	370071	0.8829	370148	1.2114	380026	1.0994
360163	1.3513	370007	1.1922	370072	0.9880	370149	1.1731	380027	1.1231
360164	1.0475	370008	1.1715	370076	1.1054	370153	1.0267	380029	1.0888
360165	0.9519	370011	0.9782	370077	1.0847	370154	0.9857	380030	0.7801
360166	0.9628	370012	0.9246	370078	1.2689	370156	0.9874	380031	0.9887
360167	0.9723	370013	1.3478	370079	0.9217	370157	0.9728	380033	1.3404
360168	0.9749	370014	0.9774	370080	1.0926	370158	0.9901	380035	1.1154
360169	0.9510	370015	1.0607	370082	0.9412	370159	1.1318	380036	1.0417
360170	1.0395	370016	1.1716	370083	0.9867	370161	1.0063	380037	1.1047
360171	1.0882	370017	0.9644	370084	0.9506	370163	0.9138	380038	1.1781
360172	1.0763	370018	1.1767	370085	0.9438	370165	0.9299	380039	1.2068
360174	1.0413	370019	0.9638	370086	1.0538	370166	0.9841	380040	0.9986
360175	1.0429	370020	1.1674	370089	1.0398	370168	0.9134	380041	0.8856
360176	1.0976	370021	1.0175	370090	1.0718	370169	1.0200	380042	1.0743
360177	1.0625	370022	1.1102	370091	1.4202	370170	1.0528	380043	1.0832
360178	1.0090	370023	1.1344	370092	0.9359	370171	0.9581	380044	1.0281
360179	1.1239	370025	1.1966	370093	1.3392	370172	1.0192	380045	1.0009
360180	1.8529	370026	1.2090	370094	1.1127	370173	1.0764	380047	1.1736
360184	1.1017	370028	1.4179	370095	1.0471	370174	0.7539	380048	0.9328
360185	1.0834	370029	1.0787	370096	1.0050	370176	1.0552	380050	1.1508
360186	0.9475	370030	1.0687	370097	1.0830	370177	1.0207	380051	1.1811
360187	1.1499	370032	1.1154	370099	0.9690	370178	1.0589	380052	1.1170
360188	1.0007	370033	1.0282	370100	0.9184	370179	0.9577	380055	1.1896

PROVIDER	CASE MIX
380056	1.0150
380059	0.9870
380060	1.2197
380061	1.3746
380062	0.8519
380063	1.1625
380064	1.0996
380065	1.0715
380066	1.1255
380068	1.0661
380069	0.9720
380070	1.0319
380071	1.1436
380072	1.0104
380074	0.9720
380075	1.1657
380077	0.9502
380078	1.0708
380079	1.1736
380081	0.9487
380082	1.1024
380083	1.0657
380084	1.2495
380087	0.8838
380088	1.0148
380089	1.1901
380090	1.2274
380091	1.1994
380094	0.9732
390001	1.1972
390002	1.1360
390003	1.0928
390004	1.1446
390005	0.9979
390006	1.3660
390007	1.0600
390008	1.0739
390009	1.2101
390010	1.0842
390011	1.1003
390012	1.1730
390013	1.0903
390014	0.9208
390015	1.0424
390016	1.0530
390017	1.0236
390018	1.1333
390019	1.0238
390020	1.0164
390021	1.0695
390022	1.1163
390023	1.0690
390024	0.7187
390025	0.8027
390026	1.1969
390027	1.2411
390028	1.3905
390029	1.2954
390030	1.0694
390031	1.1311
390032	1.1095
390034	1.0958
390035	1.2168
390036	1.1272
390037	1.1391
390039	1.0252
390040	0.9530
390041	1.1182
390042	1.1053
390043	1.0340
390044	1.3300
390045	1.1266
390046	1.2876
390047	1.2982
390048	1.1433
390049	1.2272
390050	1.4635
390051	1.5400
390052	1.0495
390054	1.1027
390055	1.5052
390056	1.0636
390057	1.2402
390058	1.1593
390059	1.1303
390060	1.1136
390061	1.1788
390062	1.0744
390063	1.3523
390064	1.1485
390065	1.1573
390066	1.1418
390067	1.3480
390068	1.1071
390069	1.0440
390070	1.0704
390071	1.0529
390072	0.9835
390073	1.1373
390074	1.1420
390075	1.1458
390076	1.1314
390077	1.0844
390078	0.9797
390079	1.4981
390080	1.1484
390081	1.2165
390083	1.1519
390084	0.9977
390086	1.0547
390087	0.9698
390088	1.1484
390090	1.3102
390091	1.0956
390092	0.9888
390093	1.0512
390095	1.0130
390096	1.2338
390097	1.1832
390098	1.3753
390099	1.0564
390100	1.3625
390101	1.1655
390102	1.2260
390103	1.0310
390104	1.0307
390106	1.0379
390107	1.1351
390108	1.1611
390109	0.9767
390110	1.0847
390111	1.5269
390112	1.1352
390113	1.1272
390114	0.9317
390115	1.1269
390116	1.1427
390117	1.0328
390118	0.9857
390119	1.1252
390121	1.1183
390122	1.0432
390123	1.1523
390125	1.1215
390126	1.1359
390127	1.0670
390128	1.1072
390130	1.0257
390131	1.1385
390132	1.0348
390133	1.2689
390135	1.1620
390136	1.1043
390137	1.0748
390138	1.2615
390139	1.2675
390142	1.3266
390143	0.7906
390145	1.1002
390146	1.0677
390147	1.0954
390148	1.0394
390149	1.0727
390150	1.0762
390151	1.1652
390152	1.0694
390153	1.1239
390154	1.0957
390155	1.1233
390156	1.1348
390157	1.1049
390158	1.2011
390159	1.1734
390160	1.0273
390161	0.9624
390162	1.1464
390163	1.1263
390164	1.4431
390165	1.0213
390166	1.1162
390167	1.1116
390168	1.0180
390169	1.1161
390170	1.5867
390171	1.0354
390172	1.1001
390173	1.0510
390174	1.4798
390176	1.0864
390177	1.0072
390178	1.2484
390179	1.1193
390180	1.1404
390181	1.0246
390183	0.9963
390184	0.9643
390185	1.1033
390186	1.0116
390187	1.0592
390188	1.0882
390189	0.9740
390191	1.0737
390192	0.9760
390193	1.0685
390194	1.0138
390195	1.3566
390197	1.1229
390198	1.0654
390199	1.1323
390200	1.0347
390201	1.1864
390203	1.1377
390204	1.0982
390205	1.1341
390206	1.1451
390209	0.9544
390211	1.0666
390213	0.9542
390215	1.0809
390217	1.0472
390219	1.1253
390220	1.0664
390222	1.1661
390223	1.4651
390224	0.9113
390225	1.0777
390226	1.3157
390228	1.1709
390229	1.2164
390231	1.2164
390232	1.0565
390233	1.2048
390234	1.0673
390235	1.3850
390236	1.0343
390237	1.3061
390238	0.7199
390240	1.0584
390242	1.1367
390244	0.8699
390245	1.1019
390246	1.0038
390247	0.9778
390249	0.9565
390252	0.7149
390256	1.4528
390258	1.1396
390260	1.1322
390261	1.6164
390262	1.1467

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
390263	1.2894	420038	1.0283	430012	1.1973	430084	0.9022	440056	0.9258
390265	1.1861	420039	1.0129	430013	1.0596	430085	0.9269	440057	0.9778
390266	1.0606	420040	1.1660	430014	1.1520	430086	0.8485	440058	1.0445
390267	1.0839	420042	1.0781	430015	1.0158	430087	0.8147	440059	1.0795
390268	1.1354	420043	1.0327	430016	1.2389	430088	1.1226	440060	0.9364
390270	1.1282	420044	1.0983	430017	0.9600	440001	1.0115	440061	1.0726
410001	1.2192	420048	0.9994	430018	0.9813	440002	1.2231	440063	1.0664
410002	1.1264	420049	1.0275	430020	0.9533	440003	1.0296	440064	0.9725
410004	1.2106	420050	0.9605	430022	0.8494	440005	1.0014	440065	0.9634
410005	1.2141	420051	1.2508	430023	0.9824	440006	1.1500	440067	1.0257
410006	1.2138	420053	0.9353	430024	1.0090	440007	1.0133	440068	1.0559
410007	1.3033	420054	1.0964	430025	0.9217	440008	0.9852	440069	1.1619
410008	1.0631	420055	0.9961	430026	0.9089	440009	1.0107	440070	0.9791
410009	1.1752	420056	1.0928	430027	1.4194	440010	0.9713	440071	1.1214
410010	0.9861	420057	1.0870	430028	0.9520	440011	1.1444	440072	1.1009
410011	1.1096	420059	1.0764	430029	0.8892	440012	1.1187	440073	1.0586
410012	1.3321	420061	1.0451	430030	1.0653	440014	0.9648	440074	0.8639
410013	1.1150	420062	1.1260	430031	0.9360	440015	1.3883	440078	0.9750
410014	1.1670	420064	1.0048	430033	0.9825	440016	0.9955	440079	0.8384
410016	1.0176	420065	1.1076	430034	0.9759	440017	1.2306	440081	1.0281
420002	1.1198	420066	0.8934	430036	0.9835	440018	1.1055	440082	1.5586
420003	1.0249	420067	0.9900	430037	0.8997	440019	1.2327	440083	0.9430
420004	1.3520	420068	1.1424	430038	1.0754	440020	0.9862	440084	1.0050
420005	1.0305	420069	1.0262	430039	0.9114	440022	1.0109	440086	0.9686
420006	1.1966	420070	1.1698	430040	1.0103	440023	0.9901	440087	0.9462
420007	1.2991	420071	1.1569	430041	1.0228	440024	1.1091	440090	0.9422
420009	1.0957	420072	0.8724	430042	1.0367	440025	1.0593	440091	1.2459
420010	1.0080	420073	1.1417	430043	1.0540	440026	1.1040	440095	0.9563
420011	1.0059	420074	0.9458	430044	0.9032	440028	0.9344	440100	0.9276
420014	1.0199	420075	0.9857	430047	1.0164	440029	1.1181	440101	0.9502
420015	1.0781	420076	0.8456	430048	0.9469	440030	1.0422	440102	1.0490
420016	1.1020	420078	1.2446	430049	0.9085	440031	0.9858	440103	1.0353
420017	0.9588	420079	1.2992	430051	0.9619	440032	1.0065	440104	1.1984
420018	1.2730	420080	1.0661	430054	0.9062	440033	1.0339	440105	0.6214
420019	1.0476	420081	0.7665	430056	0.9214	440034	1.1913	440109	1.0644
420020	1.0190	420082	1.1265	430057	0.9563	440035	1.1491	440110	0.9993
420022	1.0195	420083	1.0768	430060	1.0600	440038	1.0199	440111	1.1867
420023	1.1535	420084	0.6776	430062	0.8942	440039	1.3721	440113	1.0337
420024	0.9038	420085	1.1348	430064	0.9486	440040	0.8852	440114	1.0105
420026	1.3591	420086	1.1332	430065	0.9522	440041	0.9203	440115	0.9800
420027	1.1017	420087	1.2876	430066	0.9124	440046	1.0579	440117	0.8803
420028	0.9618	420088	1.0717	430072	1.0284	440047	0.9575	440120	1.1612
420029	2.1408	430001	1.0590	430073	1.0142	440048	1.3551	440121	1.0339
420030	1.0201	430004	1.0521	430076	0.9541	440049	1.3056	440125	1.1456
420031	0.9605	430005	1.0225	430077	1.1327	440050	1.0276	440128	0.9464
420032	0.9248	430007	1.0671	430079	1.0645	440051	0.9916	440130	1.1435
420033	1.1441	430008	1.1018	430080	0.8869	440052	0.9386	440131	1.0142
420035	0.6874	430009	0.9999	430081	0.9676	440053	1.0975	440132	0.9980
420036	1.1521	430010	1.0040	430082	0.8698	440054	0.9412	440133	1.2536
420037	1.1069	430011	1.1216	430083	0.8737	440055	1.0718	440134	1.0534

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
440135	1.1296	440202	0.8882	450060	1.0365	450128	1.1230	450192	1.0132
440136	1.0875	440203	1.0921	450063	0.9081	450129	0.7972	450193	1.9734
440137	1.0149	450002	1.1526	450064	1.2499	450130	1.2056	450194	1.0408
440141	0.9939	450004	0.9916	450065	0.9551	450131	1.0907	450195	1.1664
440142	0.8530	450005	0.9840	450066	1.1959	450132	1.3070	450196	1.1216
440143	0.9740	450007	1.2071	450068	1.2482	450133	1.1871	450197	1.0158
440144	0.9862	450008	1.1330	450069	0.9241	450134	1.0987	450200	1.2497
440145	0.9126	450010	1.1429	450070	1.0843	450135	1.2817	450201	1.0676
440146	0.9124	450011	1.1747	450072	1.0519	450136	0.8815	450203	1.0363
440147	0.7530	450013	1.2372	450073	1.0002	450137	1.1484	450206	1.0145
440148	1.0781	450014	0.9371	450074	1.0147	450140	0.8335	450207	1.1072
440149	1.0402	450015	1.2919	450077	0.9670	450141	0.8448	450208	1.1367
440150	1.0949	450016	1.2809	450078	1.0009	450142	1.0600	450209	1.1898
440151	1.0626	450018	1.3097	450079	1.0822	450143	0.9458	450210	0.9757
440152	1.2497	450019	1.1051	450080	1.0998	450144	0.9846	450211	1.1109
440153	0.8919	450020	1.0256	450081	1.0550	450145	0.8574	450213	1.2038
440154	0.8525	450021	1.3810	450082	0.9743	450146	0.8470	450214	1.0677
440156	1.1901	450022	0.9965	450083	1.2169	450147	1.1472	450217	0.8976
440157	0.9688	450023	1.1882	450084	1.0402	450148	1.1037	450218	0.9727
440159	1.0140	450024	1.1527	450085	1.0243	450149	1.1436	450219	1.0062
440160	1.0293	450025	1.2339	450087	1.1473	450150	1.0174	450221	0.9777
440161	1.3690	450027	1.0272	450090	1.0583	450151	0.9766	450222	1.1300
440162	0.9801	450028	1.1463	450092	1.0441	450152	1.1640	450224	0.9839
440166	1.3172	450029	1.1213	450093	0.9800	450153	1.2627	450229	1.1359
440167	1.1447	450031	1.1015	450094	1.0984	450154	1.1140	450230	1.0156
440168	1.0644	450032	1.0692	450095	1.0105	450155	1.0034	450231	1.3622
440170	0.6927	450033	1.3732	450096	1.1796	450157	1.0141	450233	0.9511
440171	1.0176	450034	1.3650	450097	1.1185	450160	0.8549	450234	0.9517
440173	1.0858	450035	1.1926	450098	0.9443	450162	1.2827	450235	0.9737
440174	0.9419	450037	1.1653	450099	1.0516	450163	1.0535	450236	0.9308
440175	0.9757	450039	1.1934	450101	1.1763	450164	0.9469	450237	1.2333
440176	1.0755	450040	1.3575	450102	1.2624	450165	0.9629	450239	1.1125
440177	0.9380	450041	1.0376	450104	1.0835	450166	0.9254	450241	0.9475
440178	1.1428	450042	1.4308	450107	1.2299	450169	0.9013	450242	0.8956
440180	0.9761	450043	1.1205	450108	1.0333	450170	1.0226	450243	1.0033
440181	1.0301	450044	1.3870	450109	0.9865	450174	1.0685	450246	0.9220
440182	0.9658	450045	1.2006	450110	1.0785	450175	0.9784	450247	0.9318
440183	1.1217	450046	1.1795	450111	1.0740	450176	1.1305	450248	1.0626
440184	1.0755	450047	1.0207	450112	1.1204	450177	1.0053	450249	0.9250
440185	1.0781	450048	1.0327	450113	1.0515	450178	0.9771	450250	0.8520
440186	0.9378	450050	1.0603	450115	1.0298	450179	1.1683	450253	0.9683
440187	0.9770	450051	1.4374	450116	1.1812	450181	0.8853	450256	0.9339
440189	1.1734	450052	1.0408	450118	1.1809	450182	0.8982	450258	0.8696
440191	1.1167	450053	0.9916	450119	1.1929	450183	1.1468	450259	1.0544
440192	1.0121	450054	1.3801	450121	1.2113	450184	1.2521	450261	0.9644
440193	1.0287	450055	1.0482	450122	0.9240	450185	0.8743	450263	1.0456
440194	1.0791	450056	1.2717	450123	1.1244	450187	1.2655	450264	0.8637
440196	1.0421	450057	1.1104	450124	1.3671	450188	0.9299	450267	0.8734
440197	1.1591	450058	1.2120	450126	1.1707	450190	1.0946	450268	1.0918
440200	0.9970	450059	1.1343	450127	0.9759	450191	1.1443	450269	0.9172

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450270	0.9701	450347	1.0551	450446	0.9906	450561	1.1829	450637	1.0497
450271	1.0155	450348	1.0126	450447	1.1598	450563	0.9892	450638	1.1954
450272	1.1052	450349	1.0505	450450	0.8726	450565	1.1522	450639	1.0891
450275	0.9867	450351	0.9817	450451	0.9303	450568	1.0098	450641	0.9571
450276	1.0418	450352	1.1356	450454	0.9238	450569	0.9986	450643	1.0801
450278	0.9044	450353	1.0478	450455	0.9847	450570	0.9246	450644	1.1486
450280	1.1815	450355	0.9381	450457	1.3519	450571	1.1922	450646	1.1874
450281	1.1818	450357	1.0427	450458	0.8705	450573	1.0177	450647	1.4006
450282	0.8612	450358	1.5416	450459	0.8596	450574	0.9278	450648	1.0295
450283	0.9890	450359	0.9506	450460	0.9158	450575	0.9575	450649	1.0129
450284	1.0473	450362	0.9881	450462	1.2276	450577	0.8517	450651	1.1573
450286	1.0199	450365	0.9820	450464	0.9245	450578	0.8585	450652	0.9386
450288	1.0651	450366	1.1020	450465	1.0140	450579	0.9929	450653	1.1266
450289	1.1470	450369	1.0437	450467	0.9820	450580	1.0240	450654	0.8899
450292	1.0514	450370	0.9778	450469	1.1575	450581	0.9789	450655	0.8886
450293	0.9403	450371	0.9834	450472	1.0228	450582	0.8549	450656	1.0972
450296	0.9923	450372	1.1708	450473	1.0174	450583	1.0129	450657	0.8129
450297	0.9666	450373	1.1156	450475	0.9768	450584	1.0336	450658	0.9528
450299	1.0279	450374	0.8662	450476	0.9638	450586	0.9739	450659	1.1958
450300	0.9098	450376	1.2419	450481	0.9604	450587	1.0624	450660	1.3214
450303	0.9228	450378	1.1981	450484	1.1474	450588	0.9207	450661	1.0327
450304	0.8952	450379	1.1714	450486	0.9576	450590	1.0829	450662	1.1445
450305	1.0641	450381	0.9400	450488	0.9628	450591	1.1046	450665	0.9567
450306	0.9755	450382	0.9095	450489	0.9514	450595	0.9999	450666	1.0430
450307	0.8569	450388	1.2905	450492	0.9597	450596	1.0487	450667	0.9171
450309	1.0510	450389	1.0526	450493	0.8957	450597	0.9935	450668	1.3445
450311	0.9338	450391	1.0505	450497	0.9932	450600	0.9916	450669	1.0796
450312	0.9777	450393	1.1529	450498	0.9048	450603	0.8105	450670	1.0240
450315	1.0847	450394	1.1133	450508	1.1802	450604	1.0442	450671	0.9185
450317	0.9096	450395	0.9625	450513	0.9258	450605	1.1315	450672	1.2533
450319	0.9181	450399	0.9487	450514	1.0705	450607	0.8285	450673	1.0969
450320	1.1313	450400	0.9666	450517	0.9312	450609	0.8963	450674	0.9203
450321	0.8340	450402	1.1062	450518	1.0928	450610	1.1742	450675	1.1164
450322	0.9109	450403	1.1802	450523	1.1666	450614	0.9126	450676	0.9598
450324	1.2040	450410	0.9877	450527	0.9989	450615	0.9303	450677	1.2056
450325	0.9603	450411	0.9471	450530	1.1342	450617	1.1019	450678	1.1764
450327	0.9393	450415	1.0905	450534	0.8737	450620	1.0334	450679	0.9281
450328	0.9770	450416	1.1273	450535	1.0667	450621	0.8931	450681	1.1805
450330	1.0716	450417	0.9279	450537	1.1133	450623	1.0460	450682	1.0947
450331	1.0432	450418	1.2182	450538	1.0647	450624	0.9525	450683	1.1463
450332	0.9388	450419	0.9495	450539	1.1455	450626	0.9867	450684	1.0741
450333	1.1249	450421	1.0580	450544	1.0344	450627	0.9848	450685	1.1023
450334	1.0872	450422	0.7136	450545	1.0820	450628	0.8758	450686	1.1809
450337	1.0311	450423	1.0898	450546	1.0856	450629	0.9724	450687	1.1686
450338	1.0456	450424	1.1080	450547	0.9131	450630	1.3294	450688	1.0122
450340	1.0349	450425	0.9681	450550	1.0182	450631	1.3704	450690	1.1341
450341	0.8497	450429	0.9637	450551	0.9814	450632	0.9483	450691	1.0470
450342	0.9538	450431	1.2183	450557	0.9506	450633	1.2476	450694	1.1071
450343	0.9912	450438	1.0063	450558	1.2216	450634	1.1798	450696	0.9629
450346	1.0975	450440	0.9194	450559	0.9287	450635	1.2128	450697	1.1207

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
450696	0.8735	460041	1.1437	490037	1.0288	490107	1.0559	500035	1.1993
450700	0.9528	460042	1.2124	490038	0.9937	490108	0.9030	500036	1.1493
450702	1.1178	460044	1.0933	490040	1.1527	490109	0.9144	500037	1.0533
450703	1.0608	470001	1.0725	490041	1.0308	490110	1.0195	500039	1.1312
450704	1.0696	470003	1.5173	490042	1.0156	490111	1.0404	500040	1.0144
450705	0.8230	470004	1.0926	490043	1.0984	490112	1.3271	500041	1.2325
450706	1.1078	470005	1.1639	490044	1.0891	490113	1.1032	500042	1.1495
450709	1.0172	470006	1.0933	490045	1.1393	490114	0.9967	500043	1.0690
450711	1.1251	470008	1.1600	490046	1.1650	490115	1.0427	500044	1.6034
450712	0.9369	470010	1.0475	490047	1.0988	490116	0.9515	500045	1.1503
450713	1.1142	470011	1.1523	490048	1.1056	490117	0.9296	500046	1.2177
450715	1.1541	470012	1.1273	490050	1.1569	490118	1.2490	500048	0.8977
450716	1.0771	470013	1.0330	490052	1.1942	490119	1.1409	500049	1.1603
450718	1.0779	470015	1.1095	490053	1.0585	490120	1.1971	500050	1.0981
450721	0.8756	470016	0.9930	490054	0.9735	490122	1.0763	500051	1.3429
450724	1.2360	470018	1.1048	490055	0.8310	490123	1.1105	500052	1.0936
460001	1.3915	470020	0.9503	490056	0.8919	490124	1.0940	500053	1.0865
460003	1.3564	470023	1.1435	490057	1.1094	490125	1.0900	500054	1.5822
460004	1.4526	470024	1.0973	490059	1.2293	490126	1.0583	500055	1.0314
460005	1.1715	490001	0.9275	490060	0.9291	490127	0.8940	500057	1.1098
460006	1.1929	490002	0.9263	490063	1.2624	490130	1.1175	500058	1.1777
460007	1.1686	490003	0.6064	490066	1.0186	500001	1.2865	500059	1.0974
460008	1.1020	490004	1.1236	490067	1.0671	500002	1.2569	500060	1.0754
460009	1.3831	490005	1.2678	490069	1.1750	500003	1.1646	500061	1.0123
460010	1.6642	490006	1.0498	490071	1.1860	500005	1.3461	500062	0.9470
460011	1.0509	490007	1.5301	490073	1.1656	500006	1.1054	500064	1.3349
460012	1.5095	490008	0.9921	490074	1.1744	500007	1.1579	500065	1.0911
460013	1.2254	490009	1.3544	490075	1.0658	500008	1.7143	500066	1.0169
460014	0.9313	490010	0.9774	490077	1.1273	500009	1.1865	500068	0.9874
460015	1.1154	490011	1.1614	490078	0.9087	500010	1.1350	500069	0.9953
460016	0.8411	490012	0.9785	490079	1.0842	500011	1.1652	500070	1.0808
460017	1.1918	490013	1.0606	490083	0.5958	500012	1.2978	500071	1.1211
460018	0.9526	490014	1.3172	490084	0.9955	500014	1.4789	500072	1.1064
460019	0.9931	490015	1.1758	490085	1.0155	500015	1.2170	500073	1.1109
460020	1.0461	490017	1.1803	490088	1.0319	500016	1.3179	500074	1.0495
460021	1.1571	490018	1.0128	490089	0.9967	500017	1.1888	500075	1.1338
460022	0.9819	490019	1.1417	490090	1.0727	500019	1.0834	500076	1.0528
460023	1.0820	490020	1.0192	490091	1.1615	500020	1.1418	500077	1.2081
460024	1.0147	490021	1.0265	490092	1.0542	500021	1.1817	500078	1.1902
460025	0.9058	490022	1.1095	490093	1.1391	500023	1.0768	500079	1.1461
460026	0.9306	490023	1.1533	490094	1.1299	500024	1.2078	500080	0.9057
460027	0.8452	490024	1.2798	490095	1.1104	500025	1.6904	500081	0.8534
460029	0.9513	490027	0.9371	490097	1.0127	500026	1.2074	500084	0.9687
460030	1.0562	490028	1.0974	490098	1.0651	500027	1.3180	500085	0.9966
460032	0.9353	490029	1.0538	490099	0.9843	500028	1.0417	500086	1.1091
460033	1.0147	490030	1.0538	490100	1.1155	500029	0.9535	500087	1.1531
460035	0.8549	490031	1.0376	490101	1.0706	500030	1.3090	500088	1.1782
460036	1.0175	490032	1.6497	490104	0.8602	500031	1.1146	500089	1.1288
460037	0.9650	490033	1.1269	490105	0.9394	500033	1.1058	500090	0.9338
460039	0.8916	490035	1.0611	490106	0.9189	500034	1.0836	500092	1.0509

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
500093	1.0993	510029	1.0567	520011	1.1236	520069	1.1169	520134	1.0343
500094	0.9215	510030	1.0895	520012	0.9523	520070	1.2244	520135	1.0224
500096	1.0793	510031	1.0375	520013	1.1837	520071	1.1486	520136	1.3182
500097	0.9823	510033	1.1559	520014	1.2013	520074	1.0669	520138	1.6367
500098	0.9237	510035	0.9646	520015	1.1717	520075	1.2385	520139	1.1991
500100	0.9775	510036	1.0209	520016	0.9780	520076	1.1469	520140	1.2400
500101	0.9159	510038	1.0211	520017	1.0779	520077	0.9934	520141	1.0662
500102	0.9549	510039	1.1261	520018	0.9849	520078	1.2028	520142	0.9562
500104	1.1234	510040	0.8914	520019	1.1469	520081	1.2721	520143	0.9640
500106	0.9813	510043	0.9966	520020	1.2481	520082	1.0751	520144	1.0106
500107	1.0576	510045	0.9426	520021	1.1399	520083	1.3682	520145	1.0647
500108	1.4360	510046	1.0730	520022	1.0851	520084	1.0751	520146	1.0475
500109	1.1430	510047	1.0665	520024	0.9728	520087	1.3872	520148	1.0869
500110	1.1707	510048	1.0696	520025	1.0837	520088	1.1914	520149	1.1288
500114	1.2727	510050	1.0765	520026	1.0694	520089	1.2086	520151	1.0792
500118	1.1138	510052	1.0852	520027	1.1807	520090	1.0236	520152	1.1377
500119	1.1656	510053	0.9549	520028	1.2341	520091	1.2892	520153	1.0265
500122	1.2211	510054	0.9191	520029	0.9923	520092	1.0991	520154	1.0706
500123	0.8549	510055	1.1560	520030	1.3093	520094	1.2578	520156	1.0342
500124	1.1770	510058	1.1421	520031	1.1661	520095	1.1066	520157	1.0843
500125	1.0461	510059	0.6257	520032	1.0264	520096	1.2223	520159	1.0905
500129	1.3367	510060	1.0499	520033	1.1736	520097	1.1513	520160	1.5501
500132	0.8808	510061	1.0155	520034	1.1454	520098	1.4938	520161	1.0163
500133	1.1877	510062	1.1174	520035	1.1710	520100	1.1097	520167	1.1563
500135	1.1394	510063	1.0792	520037	1.4242	520101	1.0595	520170	1.1891
510001	1.1495	510064	1.0391	520038	1.1418	520102	1.1073	520171	1.0903
510002	1.1031	510065	0.9722	520039	1.0353	520103	1.2281	520173	1.1114
510003	1.0342	510066	1.0363	520040	1.2274	520104	0.9830	520174	1.4172
510004	0.9769	510067	1.0496	520041	1.0898	520105	1.0072	520175	0.9622
510005	0.9993	510068	1.0368	520042	1.0538	520107	1.1190	520177	1.3292
510006	1.1281	510070	1.0003	520043	1.3423	520109	1.0732	520178	1.0878
510007	1.1824	510071	1.0935	520044	1.1930	520110	1.0433	520180	0.9772
510008	1.0582	510072	1.0475	520045	1.3516	520111	1.1104	530001	1.1115
510009	1.0598	510074	0.8794	520047	0.9977	520112	1.0651	530002	1.0931
510011	1.0344	510076	0.9301	520048	1.2373	520113	1.1436	530003	0.9411
510012	1.0344	510077	0.9509	520049	1.5461	520114	1.0774	530004	0.9885
510013	1.0111	510080	0.9419	520051	1.5291	520115	1.2229	530005	0.9858
510014	1.0141	510081	1.0007	520053	1.0586	520116	1.0899	530006	1.0557
510015	1.0052	510082	1.0076	520054	1.0421	520117	1.0288	530007	1.0396
510016	0.9589	510084	1.0141	520056	1.1256	520118	0.9749	530008	1.1220
510018	1.0663	510085	1.1123	520057	1.0569	520120	1.1513	530009	1.0039
510019	0.9810	520001	1.1916	520058	1.0959	520121	1.0530	530010	1.1030
510020	1.1888	520002	1.2211	520059	1.1120	520122	1.0520	530011	1.1439
510022	1.3145	520003	1.0795	520060	1.0144	520123	1.1068	530012	1.2388
510023	1.0109	520004	1.1326	520062	1.1414	520124	1.1012	530014	1.0943
510024	1.1400	520006	1.1037	520063	1.1362	520126	0.9487	530015	1.1022
510025	0.9731	520007	1.0178	520064	1.3774	520127	0.9845	530016	1.3439
510026	1.0111	520008	1.1722	520066	1.1551	520130	0.9731	530017	0.8574
510027	1.0285	520009	1.2329	520067	1.3275	520131	1.0186	530018	0.9179
510028	1.0392	520010	1.1008	520068	1.0150	520132	1.2364	530019	0.9515

PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX	PROVIDER	CASE MIX
530021	1.0449								
530022	0.9678								
530023	0.9318								
530024	0.9214								
530025	1.0708								
530026	1.0892								
530027	0.8769								
530029	0.9697								
530031	1.0224								

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Table 3d.—Average Case-Mix Indexes by Hospital Classification Group for FY 1985

Urban hospitals:	
Less than 100	1.0352
100 to 404	1.1520
405 to 684	1.2567
685 and above	1.2843
Rural hospitals:	
Less than 100	.9976
100 to 169	1.0714
170 and above	1.1158

Table 4a.—Wage Index for Urban Areas

Urban area (constituent counties or county equivalents)	Wage index
Abilene, TX (Taylor, TX)	.8936
Akron, OH (Portage, OH; Summit, OH)	1.0998
Albany, GA (Dougherty, GA; Lee, GA)	.8123
Albany-Schenectady-Troy, NY (Albany, NY; Greene, NY; Montgomery, NY; Rensselaer, NY; Saratoga, NY; Schenectady, NY)	.9180
Albuquerque, NM (Bernalillo, NM)	1.0997
Alexandria, LA (Rapides, LA)	.9101
Allentown-Bethlehem, PA–NJ (Warren, NJ; Carbon, PA; Lehigh, PA; Northampton, PA)	1.0378
Altoona, PA (Blair, PA)	.9949
Amarillo, TX (Potter, TX; Randall, TX)	.9525
Anaheim-Santa Ana, CA (Orange, CA)	1.2523
Anchorage, AK (Anchorage, AK)	1.5733
Anderson, IN (Madison, IN)	.9701
Anderson, SC (Anderson, SC)	.8308
Ann Arbor, MI (Washtenaw, MI)	1.2514
Anniston, AL (Calhoun, AL)	.8456
Appleton-Oshkosh-Neenah, WI (Calumet, WI; Outagamie, WI; Winnebago, WI)	1.0587
Asheville, NC (Buncombe, NC)	.8779
Athens, GA (Clarke, GA; Jackson, GA; Madison, GA; Oconee, GA)	.8119
Atlanta, GA (Barrow, GA; Butts, GA; Cherokee, GA; Clayton, GA; Cobb, GA; Coweta, GA; De Kalb, GA; Douglas, GA; Fayette, GA; Forsyth, GA; Fulton, GA; Gwinnett, GA; Henry, GA; Newton, GA; Paulding, GA; Rockdale, GA; Spalding, GA; Walton, GA)	.9592
Atlantic City, NJ (Atlantic, NJ; Cape May, NJ)	1.0488
Augusta, GA–SC (Columbia, GA; McDuffie, GA; Richmond, GA; Aiken, SC)	.9531
Aurora-Elgin, IL (Kane, IL; Kendall, IL)	1.0935
Austin, TX (Hays, TX; Travis, TX; Williamson, TX)	1.1095
Bakersfield, CA (Kern, CA)	1.1970
Baltimore, MD (Anne Arundel, MD; Baltimore, MD; Baltimore City, MD; Carroll, MD; Harford, MD; Howard, MD; Queen Annes, MD)	1.1068
Bangor, ME (Penobscot, ME)	.9216
Baton Rouge, LA (Ascension, LA; East Baton Rouge, LA; Livingston, LA; West Baton Rouge, LA)	.9753
Battle Creek, MI (Calhoun, MI)	1.0226
Beaumont-Port Arthur, TX (Hardin, TX; Jefferson, TX; Orange, TX)	1.0008
Beaver County, PA (Beaver, PA)	1.0838
Bellingham, WA (Whatcom, WA)	1.1387
Benton Harbor, MI (Berrien, MI)	.8845
Bergen-Passaic, NJ (Bergen, NJ; Passaic, NJ)	1.0669
Billings, MT (Yellowstone, MT)	1.0151
Biloxi-Gulfport, MS (Hancock, MS; Harrison, MS)	.8427
Binghamton, NY (Broome, NY; Tioga, NY)	.9488
Birmingham, AL (Blount, AL; Jefferson, AL; Saint Clair, AL; Shelby, AL; Walker, AL)	.9592
Bismarck, ND (Burleigh, ND; Morton, ND)	.9870
Bloomington, IN (Monroe, IN)	.9826
Bloomington-Normal, IL (McLean, IL)	.9772
Boise City, ID (Ada, ID)	1.0506
Boston-Lawrence-Salem-Lowell-Brockton, MA (Essex, MA; Middlesex, MA; Norfolk, MA; Plymouth, MA; Suffolk, MA)	1.1475
Boulder-Longmont, CO (Boulder, CO)	1.1242
Bradenton, FL (Manatee, FL)	.9128
Brazoria, TX (Brazoria, TX)	.8678
Bremerton, WA (Kitsap, WA)	.9741
Bridgeport-Stamford-Norwalk-Danbury, CT (Fairfield, CT)	1.1759
Brownsville-Harlingen, TX (Cameron, TX)	.8911
Bryan-College Station, TX (Brazos, TX)	.9499
Buffalo, NY (Erie, NY)	1.0608
Burlington, NC (Alamance, NC)	.7867
Burlington, VT (Chittenden, VT; Grand Isle, VT)	1.0056
Canton, OH (Carroll, OH; Stark, OH)	1.0006
Casper, WY (Natrona, WY)	1.0982
Cedar Rapids, IA (Linn, IA)	1.0099
Champaign-Urbana-Rantoul, IL (Champaign, IL)	.9892
Charleston, SC (Berkeley, SC; Charleston, SC; Dorchester, SC)	.8846
Charleston, WV (Kanawha, WV; Putnam, WV)	1.0405
Charlotte-Gastonia-Rock Hill, NC-SC (Cabarrus, NC; Gaston, NC; Lincoln, NC; Mecklenburg, NC; Rowan, NC; Union, NC; York, SC)	.8925
Charlottesville, VA (Albermarle, VA; Charlottesville City, VA; Fluvanna, VA; Greene, VA)	.9276
Chattanooga, TN-GA (Catoosa, GA; Dade, GA; Walker, GA; Hamilton, TN; Marion, TN; Sequatchie, TN)	.9967
Cheyenne, WY (Laramie, WY)	.9630
Chicago, IL (Cook, IL; Du Page, IL; McHenry, IL)	1.2260
Chico, CA (Butte, CA)	1.2372
Cincinnati, OH-KY-IN (Dearborn, IN; Boone, KY; Campbell, KY; Kenton, KY; Clermont, OH; Hamilton, OH; Warren, OH)	1.0969
Clarksville-Hopkinsville, TN-KY (Christian, KY; Montgomery, TN)	.8123
Cleveland, OH (Cuyahoga, OH; Geauga, OH; Lake, OH; Medina, OH)	1.1479
Colorado Springs, CO (El Paso, CO)	1.0362
Columbia, MO (Boone, MO)	1.0941
Columbia, SC (Lexington, SC; Richland, SC)	.9100
Columbus, GA–AL (Russell, AL; Chattanoochee, GA; Muscogee, GA)	.7871
Columbus, OH (Delaware, OH; Fairfield, OH; Franklin, OH; Licking, OH; Madison, OH; Pickaway, OH; Union, OH)	.9613
Corpus Christi, TX (Nueces, TX; San Patricio, TX)	.9826
Cumberland, MD–WV (Allegeny, MD; Mineral, WV)	.8930
Dallas, TX (Collin, TX; Dallas, TX; Denton, TX; Ellis, TX; Kaufman, TX; Rockwall, TX)	1.0654
Danville, VA (Danville City, VA; Pittsylvania, VA)	.8027
Davenport-Rock Island-Moline, IA–IL (Scott, IA; Henry, IL; Rock Island, IL)	1.0582
Dayton-Springfield, OH (Clark, OH; Greene, OH; Miami, OH; Montgomery, OH)	1.0859
Daytona Beach, FL (Volusia, FL)	.9071
Decatur, IL (Macon, IL)	.9522
Denver, CO (Adams, CO; Arapahoe, CO; Denver, CO; Douglas, CO; Jefferson, CO)	1.2770
Des Moines, IA (Dallas, IA; Polk, IA; Warren, IA)	1.0479
Detroit, MI (Lapeer, MI; Livingston, MI; Macomb, MI; Monroe, MI; Oakland, MI; Saint Clair, MI; Wayne, MI)	1.1639
Dothan, AL (Dale, AL; Houston, AL)	.8395
Dubuque, IA (Dubuque, IA)	1.0512
Duluth, MN–WI (St. Louis, MN; Douglas, WI)	.9857
Eau Claire, WI (Chippewa, WI; Eau Claire, WI)	.9428
El Paso, TX (El Paso, TX)	.9367
Elkhart-Goshen, IN (Elkhart, IN)	.9579
Elmira, NY (Chemung, NY)	.9669
Enid, OK (Garfield, OK)	.9555
Erie, PA (Erie, PA)	.9917
Eugene-Springfield, OR (Lane, OR)	1.1081

Table 4a.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Evansville, IN–KY (Posey, IN; Vanderburgh, IN; Warrick, IN; Henderson, KY)	1.0142
Fargo-Moorhead, ND–MN (Clay, MN; Cass, ND)	1.0566
Fayetteville, NC (Cumberland, NC)	.8268
Fayetteville-Springdale, AR (Washington, AR)	.8019
Flint, MI (Genesee, MI; Shiawassee, MI)	1.1960
Florence, AL (Colbert, AL; Lauderdale, AL)	.7831
Florence, SC (Florence, SC)	.7630
Fort Collins-Loveland, CO (Larimor, CO)	1.0767
Fort Lauderdale-Hollywood-Pompano Beach, FL (Broward, FL)	1.1166
Fort Myers-Cape Coral, FL (Lee, FL)	.9463
Fort Pierce, FL (Martin, FL; St. Lucie, FL)	1.0140
Fort Smith, AR–OK (Crawford, AR; Sebastian, AR; Sequoyah, OK)	.9175
Fort Walton Beach, FL (Okaloosa, FL)	.8686
Fort Wayne, IN (Allen, IN; De Kalb, IN; Whitley, IN)	.9497
Fort Worth-Arlington, TX (Johnson, TX; Parker, TX; Tarrant, TX)	.9925
Fresno, CA (Fresno, CA)	1.1405
Gadsden, AL (Etowah, AL)	.8712
Gainesville, FL (Alachua, FL; Bradford, FL)	.9571
Galveston-Texas City, TX (Galveston, TX)	1.1328
Gary-Hammond, IN (Lake, IN; Porter, IN)	1.0897
Glens Falls, NY (Warren, NY; Washington, NY)	.9536
Grand Forks, ND (Grand Forks, ND)	.9799
Grand Rapids, MI (Kent, MI; Ottawa, MI)	1.0585
Great Falls, MT (Cascade, MT)	1.0643
Greeley, CO (Weld, CO)	1.0683
Green Bay, WI (Brown, WI)	1.0250
Greensboro-Winston-Salem-High Point, NC (Davidson, NC; Davie, NC; Forsyth, NC; Guilford, NC; Randolph, NC; Stokes, NC; Yadkin, NC)	.9319
Greenville-Spartanburg, SC (Greenville, SC; Pickens, SC; Spartanburg, SC)	.9062
Hagerstown, MD (Washington, MD)	.9515
Hamilton-Middletown, OH (Butler, OH)	1.0139
Harrisburg-Lebanon-Carlisle, PA (Cumberland, PA; Dauphin, PA; Lebanon, PA; Perry, PA)	.9795
Hartford-Middletown-New Britain-Bristol, CT (Hartford, CT; Litchfield, CT; Middlesex, CT; Tolland, CT)	1.1377
Hickory, NC (Alexander, NC; Burke, NC; Catawba, NC)	.8915
Honolulu, HI (Honolulu, HI)	1.1933

Table 4a.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Houma-Thibodaux, LA (Lafourche, LA; Terrebonne, LA)	.9161
Houston, TX (Fort Bend, TX; Harris, TX; Liberty, TX; Montgomery, TX; Waller, TX)	1.0589
Huntington-Ashland, WV-KY-OH (Boyd, KY; Carter, KY; Greenup, KY; Lawrence, OH; Cabell, WV; Wayne, WV	.9439
Huntsville, AL (Madison, AL)	.8598
Indianapolis, IN (Boone, IN; Hamilton, IN; Hancock, IN; Hendricks, IN; Johnson, IN; Marion, IN; Morgan, IN; Shelby, IN)	1.0516
Iowa City, IA (Johnson, IA)	1.2988
Jackson, MI (Jackson, MI)	1.0131
Jackson, MS; (Hinds, MS; Madison, MS; Rankin, MS)	.9285
Jackson, TN (Madison, TN)	.7858
Jacksonville, FL (Clay, FL; Duval, FL; Nassau, FL; St. Johns, FL)	.9411
Jacksonville, NC (Onslow, NC)	.7907
Janesville-Beloit, WI (Rock, WI)	.9352
Jersey City, NJ (Hudson, NJ)	1.1026
Johnson City-Kingsport-Bristol, TN-VA (Carter, TN; Hawkins, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Bristol City, VA; Scott, VA; Washington, VA)	.8553
Johnstown, PA (Cambria, PA; Somerset, PA)	.9456
Joliet, IL (Grundy, IL; Will, IL)	1.1170
Joplin, MO (Jasper, MO; Newton, MO)	.9135
Kalamazoo, MI (Kalamazoo, MI)	1.2250
Kankakee, IL (Kankakee, IL)	.9440
Kansas City, KS–MO (Johnson, KS; Leavenworth, KS; Miami, KS; Wyandotte, KS; Cass, MO; Clay, MO; Jackson, MO; Lafayette, MO; Platte, MO; Ray, MO)	1.0581
Kenosha, Wi (Kenosha, WI)	1.0795
Killeen-Temple, TX (Bell, TX; Coryell, TX)	.8784
Knoxville, TN (Anderson, TN; Blount, TN; Grainger, TN; Jefferson, TN; Knox, TN; Sevier, TN; Union, TN)	.8930
Kokomo, IN (Howard, IN; Tipton, IN)	.9797
LaCrosse, WI (LaCrosse, WI)	1.0092
Lafayette, LA (Lafayette, LA; St. Martin, LA)	1.0040
Lafayette, IN (Tippecanoe, IN)	.9096
Lake Charles, LA (Calcasieu, LA)	.9962
Lake County, IL (Lake, IL)	1.1551
Lakeland-Winter Haven, FL (Polk, FL)	.8786
Lancaster, PA (Lancaster, PA)	1.0319
Lansing-East Lansing, MI (Clinton, MI; Eaton, MI; Ingham, MI)	1.0690
Laredo, TX (Webb, TX)	.8103
Las Cruces, NM (Dona Ana, NM)	.8702
Las Vegas, NV (Clark, NV)	1.1171
Lawrence, KS (Douglas, KS)	1.0105
Lawton, OK (Comanche, OK)	.9399
Lewiston-Auburn, ME (Androscoggin, ME)	.9356

Table 4a.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Lexington-Fayette, KY (Bourbon, KY; Clark, KY; Fayette, KY; Jessamine, KY; Scott, KY; Woodford, KY)	.9800
Lima, OH (Allen, OH; Auglaize, OH)	.9793
Lincoln, NE (Lancaster, NE)	.9639
Little Rock-North Little Rock, AR (Faulkner, AR; Lonoke, AR; Pulaski, AR; Saline, AR)	1.1053
Longview-Marshall, TX (Gregg, TX; Harrison, TX)	.8348
Lorain-Elyria, OH (Lorain, OH)	1.0204
Los Angeles-Long Beach, CA (Los Angeles, CA)	1.3192
Louisville, KY–IN (Clark, IN; Floyd, IN; Harrison, IN; Bullitt, KY; Jefferson, KY; Oldham, KY; Shelby, KY)	1.0007
Lubbock, TX (Lubbock, TX)	1.0054
Lynchburg, VA (Amherst, VA; Campbell, VA; Lynchburg City, VA)	.9147
Macon-Warner Robins, GA (Bibb, GA; Houston, GA; Jones, GA; Peach, GA)	.9256
Madison, WI (Dane, WI)	1.0821
Manchester-Nashua, NH (Hillsboro, NH; Merrimack, NH)	.9507
Mansfield, OH (Richland, OH)	.9846
McAllen-Edinburg-Mission, TX (Hidalgo, TX)	.8045
Medford, OR (Jackson, OR)	1.0279
Melbourne-Titusville, FL (Brevard, FL)	.9309
Memphis, TN–AR–MS (Crittenden, AR; De Soto, MS; Shelby, TN; Tipton, TN)	1.0417
Miami-Hialeah, FL (Dade, FL)	1.0624
Middlesex-Somerset-Hunterdon, NJ (Hunterdon, NJ; Middlesex, NJ; Somerset, NJ)	1.0273
Midland, TX (Midland, TX)	1.1221
Milwaukee, WI (Milwaukee, WI; Ozaukee, WI; Washington, WI; Waukesha, WI)	1.1327
Minneapolis-St. Paul, MN–WI (Anoka, MN; Carver, MN; Chisago, MN; Dakota, MN; Hennepin, MN; Isanti, MN; Ramsey, MN; Scott, MN; Washington, MN; Wright, MN; St. Croix, WI)	1.1685
Mobile, AL (Baldwin, AL; Mobile, AL)	.8862
Modesto, CA (Stanislaus, CA)	1.2014
Monmouth-Ocean, NJ (Monmouth, NJ; Ocean, NJ)	.9851
Monroe, LA (Ouachita, LA)	.9274
Montgomery, AL (Autauga, AL; Elmore, AL; Montgomery, AL)	.8811
Muncie, IN (Delaware, IN)	.9991
Muskegon, MI (Muskegon, MI)	.9839
Naples, FL (Collier, FL)	1.0372
Nashville, TN (Cheatham, TN; Davidson, TN; Dickson, TN; Robertson, TN; Rutherford, TN; Sumner, TN; Williamson, TN; Wilson, TN)	.9345

Table 4a.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Nassau-Suffolk, NY (Nassau, NY; Suffolk, NY)	1.3300
New Bedford-Fall River-Attleboro, MA (Bristol, MA)	.9723
New Haven-West Haven-Waterbury-Meriden, CT (New Haven, CT)	1.1193
New London-Norwich, CT (New London, CT)	1.1021
New Orleans, LA (Jefferson, LA; Orleans, LA; St. Bernard, LA; St. Charles, LA; St. John The Baptist, LA; St. Tammany, LA)	.9275
New York, NY (Bronx, NY; Kings, NY; New York City, NY; Putnam, NY; Queens, NY; Richmond, NY; Rockland, NY; Westchester, NY	1.3707
Newark, NJ (Essex, NJ; Morris, NJ; Sussex, NJ; Union, NJ)	1.1320
Niagara Falls, NY (Niagara, NY)	.8897
Norfolk-Virginia Beach-Newport News, VA (Chesapeake City, VA; Gloucester, VA; Hampton City, VA; James City Co., VA; Newport News City, VA; Norfolk City, VA; Poquoson, VA; Portsmouth City, VA; Suffolk City, VA; Virginia Beach City, VA; Williamsburg City, VA; York, VA)	.9621
Oakland, CA (Alameda, CA; Contra Costa, CA)	1.4783
Ocala, FL (Marion, FL)	.8670
Odessa, TX (Ector, TX)	.9548
Oklahoma City, OK (Canadian, OK; Cleveland, OK; Logan, OK; McClain, OK; Oklahoma, OK; Pottawatomie, OK)	1.0850
Olympia, WA (Thurston, WA)	1.0707
Omaha, NE-IA (Pottawattamie, IA; Douglas, NE; Sarpy, NE; Washington, NE)	1.0432
Orange County, NY (Orange, NY)	.9230
Orlando, FL (Orange, FL; Osceola, FL; Seminole, FL)	1.0113
Owensboro, KY (Daviess, KY)	.8183
Oxnard-Ventura, CA (Ventura, CA)	1.2756
Panama City, FL (Bay, FL)	.8292
Parkersburg-Marietta, WV-OH (Washington, OH; Wood, WV)	.9053
Pascagoula, MS (Jackson, MS)	.9606
Pensacola, FL (Escambia, FL; Santa Rosa, FL)	.8677
Peoria, IL (Peoria, IL; Tazewell, IL; Woodford, IL)	1.0506
Philadelphia, PA-NJ (Burlington, NJ; Camden, NJ; Gloucester, NJ; Bucks, PA; Chester, PA; Delaware, PA; Montgomery, PA; Philadelphia, PA)	1.1696
Phoenix, AZ (Maricopa, AZ)	1.0722
Pine Bluff, AR (Jefferson, AR)	.7951
Pittsburgh, PA (Allegheny, PA; Fayette, PA; Washington, PA; Westmoreland, PA)	1.0930
Pittsfield, MA (Berkshire, MA)	1.0170
Portland, ME (Cumberland, ME; Sagadahoc, ME; York, ME)	.9807

Table 4a.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Portland, OR (Clackamas, OR; Multonomah, OR; Washington, OR; Yamhill, OR)	1.1985
Portsmouth-Dover-Rochester, NH (Rockingham, NH; Strafford, NH)	.9304
Poughkeepsie, NY (Dutchess, NY)	.9978
Providence-Pawtucket-Woonsocket, RI (Bristol, RI; Kent, RI; Newport, RI; Providence, RI; Statewide, RI; Washington, RI)	1.0425
Provo-Orem, UT (Utah, UT)	.9785
Pueblo, CO (Pueblo, CO)	1.1128
Racine, WI (Racine, WI)	.9928
Raleigh-Durhan, NC (Durham, NC; Franklin, NC; Orange, NC; Wake, NC)	.9649
Rapid City, SD (Pennington, SD)	.9553
Reading, PA (Berks, PA)	1.0173
Redding, CA (Shasta, CA)	1.2304
Reno, NV (Washoe, NV)	1.1752
Richland-Kennewick, WA (Benton, WA; Franklin, WA)	1.0180
Richmond-Petersburg, VA (Charles City Co., VA; Chesterfield, VA; Colonial Heights City, VA; Dinwiddie, VA; Goochland, VA; Hanover, VA; Henrico, VA; Hopewell City, VA; New Kent, VA; Petersburg City, VA; Powhatan, VA; Prince George, VA; Richmond City, VA)	.9494
Riverside-San Bernardino, CA (Riverside, CA; San Bernardino, CA)	1.2425
Roanoke, VA (Botetourt, VA; Roanoke, VA; Roanoke City, VA; Salem City, VA)	.8930
Rochester, MN (Olmsted, MN)	1.0208
Rochester, NY (Livingston, NY; Monroe, NY; Ontario, NY; Orleans, NY; Wayne, NY)	1.0151
Rockford, IL (Boone, IL; Winnebago, IL)	1.1270
Sacramento, CA (Eldorado, CA; Placer, CA; Sacramento, CA; Yolo, CA)	1.2873
Saginaw-Bay City-Midland, MI (Bay, MI; Midland, MI; Saginaw, MI)	1.0989
St. Cloud, MN (Benton, MN; Sherburne, MN; Stearns, MN)	.9944
St. Joseph, MO (Buchanan, MO)	.9417
St. Louis, MO-IL (Clinton, IL; Jersey, IL; Madison, IL; Monroe, IL; St. Clair, IL; Franklin, MO; Jefferson, MO; St. Charles, MO; St. Louis, MO; St. Louis City, MO)	1.0747
Salem, OR (Marion, OR; Polk, OR)	1.0890
Salinas-Seaside-Monterey, CA (Monterey, CA)	1.2478
Salt Lake City-Ogden, UT (Davis, UT; Salt Lake, UT; Weber, UT)	1.0277
San Angelo, TX (Tom Green, TX)	.8654
San Antonio, TX (Bexar, TX; Comal, TX; Guadalupe, TX)	.8877
San Diego, CA (San Diego, CA)	1.3007
San Francisco, CA (Marin, CA; San Francisco, CA; San Mateo, CA)	1.6395

Table 4a.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
San Jose, CA (Santa Clara, CA)	1.4696
Santa Barbara-Santa Maria-Lompoc, CA (Santa Barbara, CA)	1.1735
Santa Cruz, CA (Santa Cruz, CA)	1.2341
Santa Fe, NM (Los Alamos, NM; Santa Fe, NM)	.9737
Santa Rosa-Petaluma, CA (Sonoma, CA)	1.3016
Sarasota, FL (Sarasota, FL)	.9568
Savannah, GA (Chatham, GA; Effingham, GA)	.8851
Scranton-Wilkes Barre, PA (Columbia, PA; Lackawanna, PA; Luzerne, PA; Monroe, PA; Wyoming, PA)	.9908
Seattle, WA (King, WA; Snohomish, WA)	1.1493
Sharon, PA (Mercer, PA)	.9685
Sheboygan, WI (Sheboygan, WI)	.9812
Sherman-Denison, TX (Grayson, TX)	.8556
Shreveport, LA (Bossier, LA; Caddo, LA)	.9542
Sioux City, IA-NE (Woodbury, IA; Dakota, NE)	.9988
Sioux Falls, SD (Minnehaha, SD)	1.0135
South Bend-Mishawaka, IN (St. Joseph, IN)	1.0013
Spokane, WA (Spokane, WA)	1.1474
Springfield, IL (Menard, IL; Sangamon, IL)	1.0585
Springfield, MO (Christian, MO; Greene, MO)	.9790
Springfield, MA (Hampden, MA; Hampshire, MA)	.9986
State College, PA (Centre, PA)	1.0692
Steubenville-Weirton, OH-WV (Jefferson, OH; Brooke, WV; Hancock, WV)	.9584
Stockton, CA (San Joaquin, CA)	1.2776
Syracuse, NY (Madison, NY; Onondaga, NY; Oswego, NY)	1.0225
Tacoma, WA (Pierce, WA)	1.0971
Tallahassee, FL (Gadsden, FL; Leon, FL)	.9439
Tampa-St. Petersburg-Clearwater, FL (Hernando, FL; Hillsborough, FL; Pasco, FL; Pinellas, FL)	.9758
Terre Haute, IN (Clay, IN; Vigo, IN)	.8394
Texarkana, TX—Texarkana, AR (Miller, AR; Bowie, TX)	.8587
Toledo, OH (Fulton, OH; Lucas, OH; Wood, OH)	1.2177
Topeka, KS (Shawnee, KS)	1.0554
Trenton, NJ (Mercer, NJ)	1.0241
Tucson, AZ (Pima, AZ)	1.0016
Tulsa, OK (Creeks, OK; Osage, OK; Rogers, OK; Tulsa, OK; Wagoner, OK)	1.0056
Tuscaloosa, AL (Tuscaloosa, AL)	1.0098
Tyler, TX (Smith, TX)	.9962
Utica-Rome, NY (Herkimer, NY; Oneida, NY)	.8775
Vallejo-Fairfield-Napa, CA (Napa, CA; Solano, CA)	1.3298
Vancouver, WA (Clark, WA)	1.1573
Victoria, TX (Victoria, TX)	.8144
Vineland-Millville-Bridgeton, NJ (Cumberland, NJ)	.9856

Table 4a.—Wage Index for Urban Areas—Continued

Urban area (constituent counties or county equivalents)	Wage index
Visalia-Tulare-Porterville, CA (Tulare, CA)	1.0565
Waco, TX (McLennan, TX)	.9049
Washington, D.C.-MD-VA (District of Columbia, DC; Calvert, MD; Charles, MD; Frederick, MD; Montgomery, MD; Prince Georges, MD; Alexandria City, VA; Arlington, VA; Fairfax, VA; Fairfax City, VA; Falls Church City, VA; Loudoun, VA; Manassas City, VA; Manassas Park City, VA; Prince William, VA; Stafford, VA)	1.1876
Waterloo-Cedar Falls, IA (Black Hawk, IA; Bremer, IA)	.9919
Wausau, WI (Marathon, WI)	.9799
West Palm Beach-Boca Raton-Delray Beach, FL (Palm Beach, FL)	.9899
Wheeling, WV-OH (Belmont, OH; Marshall, WV; Ohio, WV)	.9699
Wichita, KS (Butler, KS; Sedgwick, KS)	1.1504
Wichita Falls, TX (Wichita, TX)	.8711
Williamsport, PA (Lycoming, PA)	.8981
Wilmington, DE-NJ-MD (New Castle, DE; Cecil MD; Salem, NJ)	1.0510
Wilmington, NC (New Hanover, NC)	.9521
Worcester-Fitchburg-Leominster, MA (Worcester, MA)	1.0020
Yakima, WA (Yakima, WA)	1.0312
York, PA (Adams, PA; York, PA)	.9781
Youngstown-Warren, OH (Mahoning, OH; Trumbull, OH)	1.0403
Yuba City, CA (Sutter, CA; Yuba, CA)	1.0383

Table 4b.—Wage Index for Rural Areas

Non-urban area	Wage Index
Alabama	.7411
Alaska	1.4878
Arizona	.9254
Arkansas	.7646
California	1.1372
Colorado	.9257
Connecticut	1.0383
Delaware	.8581
Florida	.8750
Georgia	.7722
Hawaii	1.0082
Idaho	.9062
Illinois	.8851
Indiana	.8621
Iowa	.8654
Kansas	.8418
Kentucky	.7977
Louisiana	.8542
Maine	.8591
Maryland	.8709
Massachusetts	1.0470
Michigan	.9479
Minnesota	.8724
Mississippi	.7648
Missouri	.8264
Montana	.9086
Nebraska	.8249
Nevada	1.0719
New Hampshire	.9183
New Jersey [1]	
New Mexico	.9145
New York	.8666
North Carolina	.8070
North Dakota	.8994
Ohio	.9033
Oklahoma	.8400
Oregon	1.0703
Pennsylvania	.9357
Rhode Island [1]	
South Carolina	.7769
South Dakota	.8202
Tennessee	.7676
Texas	.8120
Utah	.9435
Vermont	.8823
Virginia	.8134
Washington	1.0197
West Virginia	.8751
Wisconsin	.8928
Wyoming	.9673

[1] All counties within the State are classfied urban.

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TABLE 5

LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, ARITHMETIC AND GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
1	1	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.5632	21.4	16.2	33
2	1	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.8117	19.7	13.4	30
3	1	SURG *	CRANIOTOMY AGE <18	2.9183		12.7	30
4	1	SURG	SPINAL PROCEDURES	2.7300	20.2	15.0	32
5	1	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.6510	9.7	8.0	25
6	1	SURG	CARPAL TUNNEL RELEASE	.4072	2.8	2.3	7
7	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC AGE >69 &/OR CC	1.3867	11.5	6.1	23
8	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC AGE <70 W/O CC	.7466	5.6	3.7	19
9	1	MED	SPINAL DISORDERS & INJURIES	1.4237	14.4	8.4	25
10	1	MED	NERVOUS SYSTEM NEOPLASMS AGE >69 AND/OR CC	1.1324	11.6	7.8	25
11	1	MED	NERVOUS SYSTEM NEOPLASMS AGE <70 W/O CC	.9338	10.2	6.1	23
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	1.0016	11.4	7.8	25
13	1	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.9789	10.9	7.7	25
14	1	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.3144	12.6	8.5	26
15	1	MED	TRANSIENT ISCHEMIC ATTACK AND PRECEREBRAL OCCLUSIONS	.6241	6.1	4.7	19
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CC	.9044	8.9	6.8	24
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6803	7.8	5.6	23
18	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS AGE >69 AND/OR CC	.7567	8.2	6.1	23
19	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS AGE <70 W/O CC	.6548	7.2	5.3	22
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.4090	11.5	7.6	25
21	1	MED	VIRAL MENINGITIS	1.3144	10.6	7.9	25
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	.7087	6.5	5.0	20
23	1	MED	NONTRAUMATIC STUPOR & COMA	1.1242	8.5	5.2	22
24	1	MED	SEIZURE & HEADACHE AGE >69 AND/OR CC	.7644	6.6	5.0	22
25	1	MED	SEIZURE & HEADACHE AGE 18-69 W/O CC	.5522	5.5	4.0	18
26	1	MED	SEIZURE & HEADACHE AGE 0-17	.6255	3.9	2.7	14
27	1	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.5648	9.6	4.7	22
28	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >69 AND/OR CC	.9422	8.5	5.0	22
29	1	MED	TRAUMATIC STUPOR & COMA <1 HR AGE 18-69 W/O CC	.6462	6.0	3.6	21
30	1	MED *	TRAUMATIC STUPOR & COMA <1 HR AGE 0-17	.3539		2.0	8
31	1	MED	CONCUSSION AGE >69 AND/OR CC	.5383	5.7	3.9	20
32	1	MED	CONCUSSION AGE 18-69 W/O CC	.4064	4.1	2.9	14
33	1	MED *	CONCUSSION AGE 0-17	.2457		1.6	5
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE >69 AND/OR CC	.9777	8.9	6.1	23
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM AGE <70 W/O CC	.7384	7.6	4.9	22

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
*** WEIGHT, LENGTH OF STAY, AND OUTLIER THRESHOLD ARE ESTIMATED; THEY WILL BE RECOMPUTED FOR FINAL.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
36	2	SURG	RETINAL PROCEDURES	.7103	4.7	4.1	12
37	2	SURG	ORBITAL PROCEDURES	.6688	4.2	3.2	12
38	2	SURG	PRIMARY IRIS PROCEDURES	.3990	3.1	2.4	8
39	2	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5721	2.3	2.1	4
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.4129	2.5	2.1	6
41	2	SURG *	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	.3657		1.6	4
42	2	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6543	3.7	3.0	10
43	2	MED	HYPHEMA	.3462	4.6	3.7	13
44	2	MED	ACUTE MAJOR EYE INFECTIONS	.6397	7.3	5.9	21
45	2	MED	NEUROLOGICAL EYE DISORDERS	.5409	4.7	3.6	14
46	2	MED	OTHER DISORDERS OF THE EYE AGE >17 WITH CC	.6010	5.6	3.7	21
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4192	3.6	2.5	11
48	2	MED *	OTHER DISORDERS OF THE EYE AGE 0-17	.4018		2.9	13
49	3	SURG	MAJOR HEAD & NECK PROCEDURES	2.6745	17.1	13.1	30
50	3	SURG	SIALOADENECTOMY	.7034	4.4	3.7	11
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.5887	4.0	3.3	10
52	3	SURG	CLEFT LIP & PALATE REPAIR	.6956	4.4	3.5	13
53	3	SURG	SINUS & MASTOID PROCEDURES AGE >17	.6176	3.8	3.0	10
54	3	SURG *	SINUS & MASTOID PROCEDURES AGE 0-17	.6889		3.2	11
55	3	SURG	MISCELLANEOUS EAR, NOSE & THROAT PROCEDURES	.4342	2.6	2.1	6
56	3	SURG	RHINOPLASTY	.4358	2.8	2.3	7
57	3	SURG	T&A PROC EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.7718	5.7	3.7	20
58	3	SURG *	T&A PROC EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	.3097		1.5	3
59	3	SURG	TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE >17	.4132	2.9	2.3	7
60	3	SURG *	TONSILLECTOMY AND/OR ADENOIDECTOMY ONLY AGE 0-17	.2616		1.5	3
61	3	SURG	MYRINGOTOMY WITH TUBE INSERTION AGE >17	.4274	2.9	2.0	8
62	3	SURG *	MYRINGOTOMY WITH TUBE INSERTION AGE 0-17	.3089		1.3	3
63	3	SURG	OTHER EAR, NOSE & THROAT O.R. PROCEDURES	1.1619	8.1	5.1	22
64	3	MED	EAR, NOSE & THROAT MALIGNANCY	.9769	8.5	4.8	22
65	3	MED	DYSEQUILIBRIUM	.4499	4.8	3.8	14
66	3	MED	EPISTAXIS	.4146	4.3	3.3	13
67	3	MED	EPIGLOTTITIS	.9364	6.5	4.8	21
68	3	MED	OTITIS MEDIA & URI AGE >69 AND/OR CC	.6092	6.3	5.1	17
69	3	MED	OTITIS MEDIA & URI AGE 18-69 W/O CC	.5040	5.1	4.1	14
70	3	MED	OTITIS MEDIA & URI AGE 0-17	.5251	4.2	3.3	12

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** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
*** WEIGHT, LENGTH OF STAY, AND OUTLIER THRESHOLD ARE ESTIMATED; THEY WILL BE RECOMPUTED FOR FINAL.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
71	3	MED	LARYNGOTRACHEITIS	.6594	5.8	4.6	18
72	3	MED	NASAL TRAUMA & DEFORMITY	.5217	5.2	3.5	19
73	3	MED	OTHER EAR, NOSE & THROAT DIAGNOSES AGE >17	.6049	5.1	3.4	18
74	3	MED	* OTHER EAR, NOSE & THROAT DIAGNOSES AGE 0-17	.3427		2.1	9
75	4	SURG	MAJOR CHEST PROCEDURES	2.9780	16.2	13.4	30
76	4	SURG	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC	2.5667	14.9	10.3	27
77	4	SURG	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES W/O CC	1.6735	11.5	7.0	24
78	4	MED	PULMONARY EMBOLISM	1.4802	11.7	9.5	27
79	4	MED	***RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >69 AND/OR CC	1.9311	12.8	9.6	27
80	4	MED	***RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 18-69 W/O CC	1.4335	12.0	8.5	26
81	4	MED	* RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	.8652		6.1	23
82	4	MED	RESPIRATORY NEOPLASMS	1.1259	9.9	6.6	24
83	4	MED	MAJOR CHEST TRAUMA AGE >69 AND/OR CC	.8398	8.6	6.6	24
84	4	MED	MAJOR CHEST TRAUMA AGE <70 W/O CC	.5921	6.0	4.6	19
85	4	MED	PLEURAL EFFUSION AGE >69 AND/OR CC	1.1198	9.9	7.2	24
86	4	MED	PLEURAL EFFUSION AGE <70 W/O CC	.9761	8.8	5.9	23
87	4	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.8078	10.2	7.0	24
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1.0769	8.5	6.6	24
89	4	MED	***SIMPLE PNEUMONIA & PLEURISY AGE >69 AND/OR CC	1.1637	9.5	7.5	25
90	4	MED	***SIMPLE PNEUMONIA & PLEURISY AGE 18-69 W/O CC	.8828	7.7	6.2	22
91	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	.6216	5.7	4.4	19
92	4	MED	INTERSTITIAL LUNG DISEASE AGE >69 AND/OR CC	1.1117	9.0	6.8	24
93	4	MED	INTERSTITIAL LUNG DISEASE AGE <70 W/O CC	.8642	7.5	5.4	22
94	4	MED	PNEUMOTHORAX AGE >69 AND/OR CC	1.3044	10.1	7.6	25
95	4	MED	PNEUMOTHORAX AGE <70 W/O CC	.8797	7.8	5.9	23
96	4	MED	BRONCHITIS & ASTHMA AGE >69 AND/OR CC	.8448	7.3	6.0	20
97	4	MED	BRONCHITIS & ASTHMA AGE 18-69 W/O CC	.7092	6.2	5.1	17
98	4	MED	BRONCHITIS & ASTHMA AGE 0-17	.7202	4.5	3.8	12
99	4	MED	RESPIRATORY SIGNS & SYMPTOMS AGE >69 AND/OR CC	.8078	6.4	4.6	22
100	4	MED	RESPIRATORY SIGNS & SYMPTOMS AGE <70 W/O CC	.6255	5.0	3.6	16
101	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES AGE >69 AND/OR CC	.8461	7.5	5.5	23
102	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES AGE <70 WITHOUT CC	.6843	6.1	4.3	21
103	5	SURG	HEART TRANSPLANT	.0000			
104	5	SURG	CARDIAC VALVE PROCEDURE WITH PUMP & WITH CARDIAC CATH	7.3161	21.0	18.0	35
105	5	SURG	CARDIAC VALVE PROCEDURE WITH PUMP & W/O CARDIAC CATH	6.3400	18.2	15.0	32

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
106	5	SURG	CORONARY BYPASS WITH CARDIAC CATH	5.3332	16.3	14.7	32
107	5	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.6614	14.5	12.7	30
108	5	SURG	OTHER CARDIOVASCULAR OR THORACIC PROC, WITH PUMP	4.7810	14.7	10.6	26
109	5	SURG	CARDIOTHORACIC PROCEDURES W/O PUMP	4.3597	14.7	9.0	26
110	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP AGE >69 AND/OR CC	3.3215	16.4	13.1	30
111	5	SURG	MAJOR RECONSTRUCTIVE VASCULAR PROC W/O PUMP AGE <70 W/O CC	2.4581	13.1	11.2	28
112	5	SURG	VASCULAR PROCEDURES EXCEPT MAJOR RECONSTRUCTION W/O PUMP	2.2239	11.8	8.1	25
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	2.5406	21.8	17.2	34
114	5	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.8946	17.2	12.4	29
115	5	SURG	PERM CARDIAC PACEMAKER IMPLANT WITH AMI, HEART FAILURE OR SHOCK	4.1634	16.6	13.9	31
116	5	SURG	PERM CARDIAC PACEMAKER IMPLANT W/O AMI, HEART FAILURE OR SHOCK	2.9709	9.6	7.6	25
117	5	SURG	CARDIAC PACEMAKER REPLACE & REVIS EXC PULSE GEN REPL ONLY	1.4684	6.5	4.8	20
118	5	SURG	CARDIAC PACEMAKER PULSE GENERATOR REPLACEMENT ONLY	1.8784	4.7	3.4	14
119	5	SURG	VEIN LIGATION & STRIPPING	.9165	7.7	5.6	23
120	5	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.2580	17.0	11.4	28
121	5	MED	CIRCULATORY DISORDERS WITH AMI & C.V. COMP. DISCH. ALIVE	1.7694	12.4	10.3	27
122	5	MED	CIRCULATORY DISORDERS WITH AMI W/O C.V. COMP. DISCH. ALIVE	1.3270	10.6	8.8	26
123	5	MED	CIRCULATORY DISORDERS WITH AMI, EXPIRED	1.3525	5.6	3.0	20
124	5	MED	CIRCULATORY DISORDERS EXC AMI, WITH CARD CATH & COMPLEX DIAG	1.2553	7.1	5.0	22
125	5	MED	CIRCULATORY DISORDERS EXC AMI, WITH CARD CATH W/O COMPLEX DIAG	.7266	3.8	2.8	11
126	5	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.9840	23.8	18.1	35
127	5	MED	HEART FAILURE & SHOCK	1.0100	8.9	6.8	24
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	.8456	9.9	8.6	24
129	5	MED	CARDIAC ARREST, UNEXPLAINED	1.7200	7.9	3.8	21
130	5	MED	PERIPHERAL VASCULAR DISORDERS AGE >69 AND/OR CC	.8254	8.3	5.7	23
131	5	MED	PERIPHERAL VASCULAR DISORDERS AGE <70 W/O CC	.6712	5.7	4.5	22
132	5	MED	ATHEROSCLEROSIS AGE >69 AND/OR CC	.6040	7.0	5.3	22
133	5	MED	ATHEROSCLEROSIS AGE <70 W/O CC	.7050	5.2	3.8	16
134	5	MED	HYPERTENSION	.6365	6.6	5.1	20
135	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >69 AND/OR CC	.8936	7.3	5.3	22
136	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 18-69 W/O CC	.7526	5.6	3.8	18
137	5	MED *	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	.6315		3.3	20
138	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE >69 AND/OR CC	.8138	6.5	4.9	21
139	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS AGE <70 W/O CC	.6517	5.1	3.9	16
140	5	MED	ANGINA PECTORIS	.6895	5.7	4.6	16

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DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
141	5	MED	SYNCOPE & COLLAPSE AGE >69 AND/OR CC	.6188	5.7	4.4	18
142	5	MED	SYNCOPE & COLLAPSE AGE <70 W/O CC	.5335	4.7	3.6	14
143	5	MED	CHEST PAIN	.5895	4.5	3.5	13
144	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CC	1.1156	8.4	6.2	23
145	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.8477	7.1	5.0	22
146	6	SURG	RECTAL RESECTION AGE >69 AND/OR CC	3.0755	18.9	16.6	34
147	6	SURG	RECTAL RESECTION AGE <70 W/O CC	2.2737	15.4	14.0	31
148	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES AGE >69 AND/OR CC	2.9407	17.8	15.3	32
149	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O CC	2.1072	14.3	12.6	30
150	6	SURG	PERITONEAL ADHESIOLYSIS AGE >69 AND/OR CC	2.3428	14.9	12.8	30
151	6	SURG	PERITONEAL ADHESIOLYSIS AGE <70 W/O CC	1.5902	11.5	10.1	27
152	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES AGE >69 AND/OR CC	1.4069	10.8	8.6	26
153	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES AGE <70 W/O CC	1.0953	9.1	7.3	24
154	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >69 AND/OR CC	2.6880	15.1	11.5	29
155	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 18-69 W/O CC	1.7906	11.7	8.9	26
156	6	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	.6382		6.0	20
157	6	SURG	ANAL AND STOMAL PROCEDURES AGE >69 AND/OR CC	.7302	6.4	4.8	21
158	6	SURG	ANAL AND STOMAL PROCEDURES AGE <70 W/O CC	.5513	4.9	3.9	14
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >69 AND/OR CC	1.0000	7.6	6.3	22
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE 18-69 W/O CC	.7457	5.9	5.0	16
161	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >69 AND/OR CC	.6538	5.3	4.4	14
162	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE 18-69 W/O CC	.5264	4.1	3.6	10
163	6	SURG	HERNIA PROCEDURES AGE 0-17	.9648	5.6	4.2	18
164	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE>69 AND/OR CC	2.0649	12.2	10.7	26
165	6	SURG	APPENDECTOMY WITH COMPLICATED PRINC. DIAG AGE <70 W/O CC	1.4379	9.2	6.4	19
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE >69 AND/OR CC	1.3606	9.0	7.5	23
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINC. DIAG AGE <70 W/O CC	.8855	6.0	5.3	13
168	6	SURG	MOUTH PROCEDURES AGE >69 AND/OR CC	.9188	6.2	4.0	21
169	6	SURG	MOUTH PROCEDURES AGE <70 W/O CC	.6585	4.0	3.0	12
170	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE >69 AND/OR CC	2.7615	17.6	12.3	29
171	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES AGE <70 W/O CC	2.3305	15.4	9.8	27
172	6	MED	DIGESTIVE MALIGNANCY AGE >69 AND/OR CC	1.0749	10.4	6.7	24
173	6	MED	DIGESTIVE MALIGNANCY AGE <70 W/O CC	.9604	9.3	5.4	22
174	6	MED	G.I. HEMORRHAGE AGE >69 AND/OR CC	.9075	7.5	5.6	23
175	6	MED	G.I. HEMORRHAGE AGE <70 W/O CC	.7069	6.0	4.7	18

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176	6	MED	COMPLICATED PEPTIC ULCER	.9318	8.3	6.3	23
177	6	MED	UNCOMPLICATED PEPTIC ULCER >69 AND/OR CC	.6617	6.6	5.4	18
178	6	MED	UNCOMPLICATED PEPTIC ULCER <70 W/O CC	.5556	5.5	4.6	15
179	6	MED	INFLAMMATORY BOWEL DISEASE	.9877	9.6	7.1	24
180	6	MED	G.I. OBSTRUCTION AGE >69 AND/OR CC	.7584	7.4	5.4	22
181	6	MED	G.I. OBSTRUCTION AGE <70 W/O CC	.5826	5.8	4.5	18
182	6	MED	ESOPHAGITIS,GASTROENT.& MISC. DIGEST. DIS AGE >69 &/OR CC	.6034	6.1	4.8	18
183	6	MED	ESOPHAGITIS,GASTROENT.& MISC. DIGEST. DIS AGE 18-69 W/O CC	.5107	5.0	4.0	15
184	6	MED	ESOPHAGITIS, GASTROENTERITIS & MISC. DIGEST. DISORDERS AGE 0-17	.4828	3.7	2.6	12
185	6	MED	DENTAL & ORAL DIS. EXC EXTRACTIONS & RESTORATIONS,AGE >17	.7147	6.6	4.3	21
186	6	MED *	DENTAL & ORAL DIS. EXC EXTRACTIONS & RESTORATIONS,AGE 0-17	.4112		2.9	11
187	6	MED	DENTAL EXTRACTIONS & RESTORATIONS	.4211	2.9	2.3	7
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >69 AND/OR CC	.7173	6.4	4.3	21
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 18-69 W/O CC	.5272	4.6	3.3	17
190	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	.9178	6.1	4.3	21
191	7	SURG	MAJOR PANCREAS, LIVER & SHUNT PROCEDURES	4.4608	22.0	18.1	35
192	7	SURG	MINOR PANCREAS, LIVER & SHUNT PROCEDURES	4.0442	21.7	16.7	34
193	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE >69 &/OR CC	2.8120	18.4	15.7	33
194	7	SURG	BILIARY TRACT PROC EXC TOT CHOLECYSTECTOMY AGE <70 W/O CC	2.1206	15.0	12.3	29
195	7	SURG	TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE >69 AND/OR CC	2.2727	14.6	13.1	30
196	7	SURG	TOTAL CHOLECYSTECTOMY WITH C.D.E. AGE <70 W/O CC	1.5976	11.2	10.3	22
197	7	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE >69 AND/OR CC	1.7058	11.9	10.5	27
198	7	SURG	TOTAL CHOLECYSTECTOMY W/O C.D.E. AGE <70 W/O CC	1.1400	8.7	8.0	17
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3378	17.4	14.2	31
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.6286	15.8	10.9	28
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.7130	16.1	10.4	27
202	7	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.1665	10.8	7.8	25
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.0339	10.1	6.9	24
204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	.9703	8.2	6.5	24
205	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE >69 AND/OR CC	1.0720	9.5	6.7	24
206	7	MED	DISORDERS OF LIVER EXC MALIG,CIRR,ALC HEPA AGE <70 W/O CC	.7735	7.5	5.0	22
207	7	MED	DISORDERS OF THE BILIARY TRACT AGE >69 AND/OR CC	.7775	7.0	5.4	22
208	7	MED	DISORDERS OF THE BILIARY TRACT AGE <70 W/O CC	.5794	5.2	4.0	16
209	8	SURG	MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES	2.3930	15.8	14.4	31
210	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >69 AND/OR CC	2.0320	16.9	14.6	32

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211	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 18-69 W/O CC	1.7867	15.0	12.7	30
212	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.6609	9.7	8.3	23
213	8	SURG	AMPUTATIONS FOR MUSCULOSKELETAL SYSTEM & CONN. TISSUE DISORDERS	1.9753	17.1	12.1	29
214	8	SURG	BACK & NECK PROCEDURES AGE >69 AND/OR CC	1.8776	15.6	13.1	30
215	8	SURG	BACK & NECK PROCEDURES AGE <70 W/O CC	1.4261	12.0	10.2	27
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.5566	13.7	8.9	26
217	8	SURG	WND DEBRID & SKN GRFT EXC HAND,FOR MUSCSKELETAL & CONN.TISS.DIS	2.3100	18.8	11.2	28
218	8	SURG	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR AGE >69 &/OR CC	1.3798	11.2	8.9	26
219	8	SURG	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR AGE 18-69 W/O CC	1.0437	8.1	6.7	22
220	8	SURG *	LOWER EXTREM & HUMER PROC EXC HIP,FOOT,FEMUR AGE 0-17	.9242		5.3	22
221	8	SURG	KNEE PROCEDURES AGE >69 AND/OR CC	.9758	7.0	4.7	22
222	8	SURG	KNEE PROCEDURES AGE <70 W/O CC	.7113	4.7	3.4	15
223	8	SURG	***MAJOR SHOULDER/ELBOW PROC,OR OTHER UPPER EXTREMITY PROC WITH CC	1.2658	8.7	6.8	24
224	8	SURG	***SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	.7294	5.2	4.0	16
225	8	SURG	FOOT PROCEDURES	.6520	4.8	3.9	13
226	8	SURG	SOFT TISSUE PROCEDURES AGE >69 AND/OR CC	.9811	6.1	5.4	22
227	8	SURG	SOFT TISSUE PROCEDURES AGE <70 W/O CC	.6872	5.2	3.8	17
228	8	SURG	***MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC WITH CC	.8041	5.0	3.9	14
229	8	SURG	***HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.5147	3.3	2.5	9
230	8	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.0555	9.2	6.1	23
231	8	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR	.7516	5.6	3.8	19
232	8	SURG	ARTHROSCOPY	.6706	4.6	3.2	14
233	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC AGE >69 &/OR CC	1.3723	11.5	8.1	25
234	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC AGE <70 W/O CC	.9457	7.5	5.3	22
235	8	MED	FRACTURES OF FEMUR	1.4137	17.9	10.1	27
236	8	MED	FRACTURES OF HIP & PELVIS	1.0714	13.1	8.8	26
237	8	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.6049	7.4	5.4	22
238	8	MED	OSTEOMYELITIS	1.6470	15.8	11.1	28
239	8	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN.TISS.MALIGNANCY	.9272	10.6	8.0	25
240	8	MED	CONNECTIVE TISSUE DISORDERS AGE >69 AND/OR CC	.9049	9.5	7.3	24
241	8	MED	CONNECTIVE TISSUE DISORDERS AGE <70 W/O CC	.7492	8.2	6.2	23
242	8	MED	SEPTIC ARTHRITIS	1.4562	13.5	9.7	27
243	8	MED	MEDICAL BACK PROBLEMS	.6843	8.0	6.2	23
244	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES AGE >69 AND/OR CC	.6748	7.9	6.1	23
245	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES AGE <70 W/O CC	.6407	6.7	5.1	22

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246	8	MED	NON-SPECIFIC ARTHROPATHIES	.5936	6.9	5.4	21
247	8	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	.5797	6.4	4.7	21
248	8	MED	TENDONITIS, MYOSITIS & BURSITIS	.5892	6.3	4.8	20
249	8	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.7899	8.8	5.6	23
250	8	MED	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE >69 &/OR CC	.5162	5.6	3.8	20
251	8	MED	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE 18-69 W/O CC	.4004	3.5	2.5	11
252	8	MED *	FX,SPRNS,STRNS & DISL OF FOREARM,HAND,FOOT AGE 0-17	.3496		1.8	7
253	8	MED	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT AGE >69 &/OR CC	.6323	7.8	5.4	22
254	8	MED	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT AGE 18-69 W/O CC	.4931	5.8	4.0	20
255	8	MED *	FX,SPRNS,STRNS & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	.4638		2.9	15
256	8	MED	OTHER DIAGNOSES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	.6993	7.2	4.9	22
257	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR CC	1.0634	8.7	7.8	19
258	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O CC	.9698	7.6	6.9	16
259	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE >69 AND/OR CC	.8605	7.0	4.9	22
260	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY AGE <70 W/O CC	.6661	4.8	3.5	15
261	9	SURG	BREAST PROC FOR NON-MALIG EXCEPT BIOPSY & LOC EXC	.6104	4.1	3.3	11
262	9	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.4252	2.8	2.3	6
263	9	SURG	SKIN-GRAFTS AND/OR DEBRID ULCER OR CELLULITIS AGE >69 AND/OR CC	2.4177	22.1	16.1	33
264	9	SURG	SKIN-GRAFTS AND/OR DEBRID ULCER OR CELLULITIS AGE <70 W/O CC	2.1802	21.7	14.9	32
265	9	SURG	SKIN-GRAFT AND/OR DEBRID EXC SKIN ULCER OR CELLULITIS WITH CC	1.3993	11.6	7.6	25
266	9	SURG	SKIN-GRAFT AND/OR DEBRID EXC SKIN ULCER OR CELLULITIS W/O CC	.7313	6.1	4.0	21
267	9	SURG	PERIANAL & PILONIDAL PROCEDURES	.6362	5.4	4.0	17
268	9	SURG	SKIN,SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	.5690	3.9	2.8	12
269	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC AGE >69 &/OR CC	1.1338	9.6	5.5	23
270	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST O.R. PROC AGE <70 W/O CC	.7623	6.3	3.8	21
271	9	MED	SKIN ULCERS	1.2609	14.1	10.1	27
272	9	MED	MAJOR SKIN DISORDERS AGE >69 AND/OR CC	.8523	9.5	7.2	24
273	9	MED	MAJOR SKIN DISORDERS AGE <70 W/O CC	.7972	9.4	6.5	24
274	9	MED	MALIGNANT BREAST DISORDERS AGE >69 AND/OR CC	1.0368	10.9	7.0	24
275	9	MED	MALIGNANT BREAST DISORDERS AGE <70 W/O CC	.9882	10.4	5.8	23
276	9	MED	NON-MALIGANT BREAST DISORDERS	.5676	5.4	3.4	19
277	9	MED	CELLULITIS AGE >69 AND/OR CC	.8866	9.2	7.3	24
278	9	MED	CELLULITIS AGE 18-69 W/O CC	.7594	7.9	6.2	23
279	9	MED *	CELLULITIS AGE 0-17	.4739		4.2	13
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >69 &/OR CC	.5417	6.4	4.6	22

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281	9 MED		TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 18-69 W/O CC	.4468	4.8	3.4	16
282	9 MED	*	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	.3424		2.2	9
283	9 MED		MINOR SKIN DISORDERS AGE >69 AND/OR CC	.6368	7.0	5.0	22
284	9 MED		MINOR SKIN DISORDERS AGE <70 W/O CC	.5172	5.3	3.7	18
285	10 SURG		AMPUTATION OF LOWER LIMB FOR ENDOCRINE,NUTRITIONAL&METABOLIC DIS.	3.2724	28.0	21.5	39
286	10 SURG		ADRENAL & PITUITARY PROCEDURES	2.6731	15.8	13.3	30
287	10 SURG		SKIN GRAFTS & WOUND DEBRIDE FOR ENDOC,NUTRIT & METAB DISORDERS	2.3781	21.5	15.7	33
288	10 SURG		O.R. PROCEDURES FOR OBESITY	2.1130	12.4	9.7	27
289	10 SURG		PARATHYROID PROCEDURES	1.3308	8.8	6.9	24
290	10 SURG		THYROID PROCEDURES	.8563	5.9	5.0	14
291	10 SURG		THYROGLOSSAL PROCEDURES	.6073	4.2	3.4	11
292	10 SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC AGE > 69 &/OR CC	2.3131	16.7	11.3	28
293	10 SURG		OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC AGE <70 W/O CC	1.7962	14.0	8.2	25
294	10 MED		DIABETES AGE =>36	.7454	8.3	6.7	24
295	10 MED		DIABETES AGE 0-35	.7886	6.7	5.0	22
296	10 MED		NUTRITIONAL & MISC. METABOLIC DISORDERS AGE >69 AND/OR CC	.8271	8.3	6.1	23
297	10 MED		NUTRITIONAL & MISC. METABOLIC DISORDERS AGE 18-69 W/O CC	.6998	7.0	4.9	22
298	10 MED		NUTRITIONAL & MISC. METABOLIC DISORDERS AGE 0-17	.7202	5.3	3.3	18
299	10 MED		INBORN ERRORS OF METABOLISM	.8080	7.7	5.3	22
300	10 MED		ENDOCRINE DISORDERS AGE >69 AND/OR CC	.9349	9.2	6.9	24
301	10 MED		ENDOCRINE DISORDERS AGE <70 W/O CC	.6882	6.9	5.1	22
302	11 SURG		KIDNEY TRANSPLANT	4.6273	24.6	21.3	38
303	11 SURG		KIDNEY,URETER & MAJOR BLADDER PROCEDURE FOR NEOPLASM	2.7610	16.6	14.2	31
304	11 SURG		KIDNEY,URETER & MAJ BLDR PROC FOR NON-NEOPL AGE >69 &/OR CC	2.0323	13.5	10.8	28
305	11 SURG		KIDNEY,URETER & MAJ BLDR PROC FOR NON-NEOPL AGE <70 W/O CC	1.4894	10.4	8.4	25
306	11 SURG		PROSTATECTOMY AGE >69 AND/OR CC	1.2595	9.8	8.1	25
307	11 SURG		PROSTATECTOMY AGE <70 W/O CC	.9587	7.7	6.5	19
308	11 SURG		MINOR BLADDER PROCEDURES AGE >69 AND/OR CC	1.1490	8.8	6.1	23
309	11 SURG		MINOR BLADDER PROCEDURES AGE <70 W/O CC	.8665	6.7	4.7	22
310	11 SURG		TRANSURETHRAL PROCEDURES AGE >69 AND/OR CC	.7266	5.6	4.3	17
311	11 SURG		TRANSURETHRAL PROCEDURES AGE <70 W/O CC	.5563	4.1	3.3	11
312	11 SURG		URETHRAL PROCEDURES, AGE >69 AND/OR CC	.7308	5.8	4.4	18
313	11 SURG		URETHRAL PROCEDURES, AGE 18-69 W/O CC	.5936	4.7	3.5	14
314	11 SURG	*	URETHRAL PROCEDURES, AGE 0-17	.4323		2.3	11
315	11 SURG		OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.7760	15.4	9.8	27

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316	11	MED	RENAL FAILURE	1.3212	10.0	6.4	23
317	11	MED	ADMIT FOR RENAL DIALYSIS	.4907	3.4	2.3	10
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS AGE >69 AND/OR CC	.9231	8.8	5.5	23
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS AGE <70 W/O CC	.7418	6.6	3.6	21
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >69 AND/OR CC	.8629	8.2	6.5	24
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 18-69 W/O CC	.6753	6.4	5.1	19
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	.6998	6.4	5.2	19
323	11	MED	URINARY STONES AGE >69 &/OR CC, &/OR ESW LITHOTRIPSY	.5663	5.1	3.7	17
324	11	MED	URINARY STONES AGE <70 W/O CC, & W/O ESW LITHOTRIPSY	.4098	3.6	2.8	11
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >69 AND/OR CC	.6504	6.5	4.6	22
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 18-69 W/O CC	.5159	4.9	3.5	16
327	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	.5511	26.6	3.3	20
328	11	MED	URETHRAL STRICTURE AGE >69 AND/OR CC	.5939	5.4	4.0	18
329	11	MED	URETHRAL STRICTURE AGE 18-69 W/O CC	.4870	4.1	3.0	12
330	11	MED *	URETHRAL STRICTURE AGE 0-17	.2788		1.6	5
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >69 AND/OR CC	.8333	7.6	5.4	22
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 18-69 W/O CC	.6740	6.0	4.1	21
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	.7915	5.9	3.7	21
334	12	SURG	MAJOR MALE PELVIC PROCEDURES WITH CC	1.8038	13.5	12.3	28
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.4644	11.9	11.0	23
336	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE >69 AND/OR CC	.9871	7.9	7.0	18
337	12	SURG	TRANSURETHRAL PROSTATECTOMY AGE <70 W/O CC	.7788	6.3	5.8	12
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	.8907	7.3	4.9	22
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANT AGE >17	.5766	4.4	3.4	12
340	12	SURG *	TESTES PROCEDURES, NON-MALIGNANT AGE 0-17	.4335		2.4	7
341	12	SURG	PENIS PROCEDURES	.9974	6.4	5.3	16
342	12	SURG	CIRCUMCISION AGE >17	.4266	3.0	2.4	8
343	12	SURG *	CIRCUMCISION AGE 0-17	.3788		1.7	4
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.1216	8.3	6.3	23
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIG	.8196	6.5	4.8	22
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE >69 AND/OR CC	.8569	8.5	5.6	23
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, AGE <70 W/O CC	.6441	5.9	3.7	21
348	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE >69 AND/OR CC	.6260	5.6	3.9	19
349	12	MED	BENIGN PROSTATIC HYPERTROPHY AGE <70 W/O CC	.4854	3.9	2.9	12
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6270	5.9	4.8	17

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351	12	MED	STERILIZATION, MALE	.3334	1.9	1.6	5
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5388	4.8	3.3	16
353	13	SURG	***PELVIC EVISCERATION, RADICAL HYSTERECTOMY & VULVECTOMY	2.3844	17.2	14.6	32
354	13	SURG	***UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIGN AGE >69 OR CC	1.3465	10.2	9.2	22
355	13	SURG	***UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIGN AGE < 70 W/O C	1.0974	8.4	7.9	16
356	13	SURG	***FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	.8431	7.6	7.0	15
357	13	SURG	***UTERINE & ADNEXA PROCEDURES, FOR OVARIAN OR ADNEXAL MALIGNANCY	2.1081	14.5	12.7	30
358	13	SURG	***UTERINE & ADNEXA PROC FOR OTHER THAN MALIGNANCY, AGE > 69 OR CC	1.0969	9.0	8.2	18
359	13	SURG	***UTERINE & ADNEXA PROC FOR OTHER THAN MALIGNANCY AGE < 70 W/O CC	.9797	7.7	7.3	15
360	13	SURG	***VAGINA, CERVIX & VULVA PROCEDURES	.6355	5.1	3.6	17
361	13	SURG	***LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	.6504	4.4	3.1	14
362	13	SURG	***ENDOSCOPIC TUBAL INTERRUPTION	.3589	2.0	1.8	4
363	13	SURG	D&C,CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.6176	4.9	3.6	15
364	13	SURG	D&C,CONIZATION EXCEPT FOR MALIGNANCY	.3922	2.8	2.3	7
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9086	14.0	10.9	28
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE >69 AND/OR CC	.8626	8.4	4.9	22
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM AGE <70 W/O CC	.5354	4.7	2.8	16
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	.7610	7.8	5.9	23
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	.5498	5.6	3.9	20
370	14	SURG	CESAREAN SECTION WITH CC	1.0856	7.9	7.1	16
371	14	SURG	CESAREAN SECTION W/O CC	.7670	6.2	5.6	12
372	14	MED	VAGINAL DELIVERY WITH COMPLICATING DIAGNOSES	.5945	5.2	4.0	14
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3538	3.1	2.8	7
374	14	SURG	VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C	.5755	3.7	3.3	8
375	14	SURG	* VAGINAL DELIVERY WITH O.R. PROC EXCEPT STERIL AND/OR D&C	.6817		4.4	15
376	14	MED	POSTPARTUM AND POSTABORTION DIAGNOSES W/O O.R. PROCEDURE	.4523	4.9	3.3	16
377	14	SURG	POSTPARTUM AND POSTABORTION DIAGNOSES WITH O.R. PROCEDURE	.7886	4.3	3.3	15
378	14	MED	ECTOPIC PREGNANCY	.7358	5.2	4.3	14
379	14	MED	THREATENED ABORTION	.2409	2.6	1.9	6
380	14	MED	ABORTION W/O D&C	.3609	2.8	1.9	9
381	14	MED	ABORTION WITH D&C, ASPIRATION CURETTAGE, OR HYSTEROTOMY	.3783	2.1	1.7	5
382	14	MED	FALSE LABOR	.1137	1.5	1.2	3
383	14	MED	OTHER ANTEPARTUM DIAGNOSES WITH MEDICAL COMPLICATIONS	.4453	4.8	3.4	16
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	.4586	4.4	2.6	16
385	15		* NEONATES, DIED OR TRANSFERRED	.6811		1.8	14

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386	15		*	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	3.6480		17.9	35
387	15		*	PREMATURITY WITH MAJOR PROBLEMS	1.8267		13.3	30
388	15		*	PREMATURITY W/O MAJOR PROBLEMS	1.1571		8.6	26
389	15		*	FULL TERM NEONATE WITH MAJOR PROBLEMS	.5425		4.7	16
390	15		*	NEONATES WITH OTHER SIGNIFICANT PROBLEMS	.3486		3.4	9
391	15		*	NORMAL NEWBORNS	.2218		3.1	7
392	16	SURG		SPLENECTOMY AGE >17	3.2494	17.3	13.7	31
393	16	SURG	*	SPLENECTOMY AGE 0-17	1.5206		9.1	26
394	16	SURG		OTHER O.R. PROCEDURES OF THE BLOOD & BLOOD FORMING ORGANS	1.0891	8.0	5.0	22
395	16	MED		RED BLOOD CELL DISORDERS AGE >17	.7153	6.7	4.7	22
396	16	MED		RED BLOOD CELL DISORDERS AGE 0-17	.2952	1.7	1.3	4
397	16	MED		COAGULATION DISORDERS	.9971	8.4	5.9	23
398	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE >69 AND/OR CC	.9753	6.1	5.5	23
399	16	MED		RETICULOENDOTHELIAL & IMMUNITY DISORDERS AGE <70 W/O CC	.7247	6.4	4.2	21
400	17	SURG		LYMPHOMA & LEUKEMIA WITH MAJOR O.R. PROCEDURE	2.6646	16.7	12.8	30
401	17	SURG	***	LYMPHOMA & NON-ACUTE LEUKEMIA WITH OTHER O.R. PROC WITH CC	1.9445	14.4	10.2	27
402	17	SURG	***	LYMPHOMA & NON-ACUTE LEUKEMIA WITH OTHER O.R. PROCEDURE W/O CC	1.0545	6.7	6.0	23
403	17	MED	***	LYMPHOMA & NON-ACUTE LEUKEMIA WITH CC	1.3481	10.9	7.3	24
404	17	MED	***	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.9142	6.7	5.4	22
405	17	MED	*	ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURE AGE < 18	1.0407		4.9	22
406	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPLASM W MAJ O.R.PROC & CC	2.5307	16.8	12.9	30
407	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.7127	13.0	8.6	26
408	17	SURG		MYELOPROLIF DISORD OR POORLY DIFF NEOPL WITH OTHER O.R.PROC	1.0502	8.3	5.3	22
409	17	MED		RADIOTHERAPY	.9856	10.9	7.0	24
410	17	MED		CHEMOTHERAPY	.4285	3.1	2.4	9
411	17	MED		HISTORY OF MALIGNANCY W/O ENDOSCOPY	.5907	5.9	3.8	21
412	17	MED		HISTORY OF MALIGNANCY WITH ENDOSCOPY	.3389	2.4	1.9	6
413	17	MED		OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE>69 &/OR C.C	1.0457	10.7	6.9	24
414	17	MED		OTHR MYELOPROLIF DISORD OR POORLY DIFF NEOPL DX AGE<70 W/O CC	.8984	9.2	5.4	22
415	18	SURG		O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.3292	20.5	14.7	32
416	18	MED		SEPTICEMIA AGE >17	1.6183	11.7	8.3	25
417	18	MED		SEPTICEMIA AGE 0-17	1.1532	7.6	5.4	22
418	18	MED		POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0026	9.8	7.5	25
419	18	MED		FEVER OF UNKNOWN ORIGIN AGE >69 AND/OR CC	.9306	8.4	6.1	23
420	18	MED		FEVER OF UNKNOWN ORIGIN AGE 18-69 W/O CC	.8319	7.5	5.5	23

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421	18	MED	VIRAL ILLNESS AGE >17	.5674	5.8	4.6	16
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	.6582	5.2	3.6	18
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.3207	11.0	8.0	25
424	19	SURG	O.R. PROCEDURES WITH PRINCIPAL DIAGNOSIS OF MENTAL ILLNESS	2.2112	22.1	15.0	32
425	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION	.6097	7.6	4.8	22
426	19	MED	DEPRESSIVE NEUROSES	.8330	11.8	7.8	25
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.7019	9.8	6.4	23
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.8513	11.9	7.4	24
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8424	11.0	7.6	25
430	19	MED	PSYCHOSES	1.0762	15.5	10.5	28
431	19	MED	CHILDHOOD MENTAL DISORDERS	.8495	10.4	6.6	24
432	19	MED	OTHER DIAGNOSES OF MENTAL DISORDERS	.6969	8.1	4.9	22
433	20		ALCOHOL/DRUG USE AND INDUCED ORGANIC MENTAL DISORDERS, LEFT AMA	.3906	4.4	2.9	16
434	20		ALC/DRUG ABUSE,INTOX INDUCD MNTL SYN EXC DEPEND &/OR OTH SYMPT TR	.7098	8.2	5.4	22
435	20		ALCOHOL/DRUG DEPENDENCE, DETOX AND/OR OTHER SYMPTOMATIC TREATMENT	.7980	10.2	6.7	24
436	20		ALCOHOL/DRUG DEPENDENCE WITH REHABILITATION THERAPY	1.0166	14.2	9.8	27
437	20		ALCOHOL/DRUG DEPENDENCE, COMBINED REHABILITATION AND DETOX THERAP	1.3276	19.0	14.6	32
438			NO LONGER VALID	.0000			
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.7930	15.4	9.0	26
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	2.0315	15.8	9.3	26
441	21	SURG	HAND PROCEDURES FOR INJURIES	.7305	4.6	2.7	16
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE >69 AND/OR CC	1.8156	10.5	6.1	23
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES AGE <70 W/O CC	1.4872	9.4	5.6	23
444	21	MED	MULTIPLE TRAUMA AGE >69 AND/OR CC	.7074	7.7	5.4	22
445	21	MED	MULTIPLE TRAUMA AGE 18-69 W/O CC	.6015	6.2	4.1	21
446	21	MED *	MULTIPLE TRAUMA AGE 0-17	.4796		2.4	10
447	21	MED	ALLERGIC REACTIONS AGE >17	.4471	4.1	2.9	14
448	21	MED *	ALLERGIC REACTIONS AGE 0-17	.3470		2.9	9
449	21	MED	POISONING AND TOXIC EFFECTS OF DRUGS AGE >69 AND/OR CC	.6954	6.5	4.7	22
450	21	MED	POISONING AND TOXIC EFFECTS OF DRUGS AGE 18-69 W/O CC	.5422	5.1	3.3	18
451	21	MED	POISONING AND TOXIC EFFECTS OF DRUGS AGE 0-17	.5498	5.0	3.4	20
452	21	MED	COMPLICATIONS OF TREATMENT AGE >69 AND/OR CC	.8080	7.0	4.7	22
453	21	MED	COMPLICATIONS OF TREATMENT AGE <70 W/O CC	.7505	6.5	4.3	21
454	21	MED	OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE >69 AND/OR CC	.8098	7.5	4.6	22
455	21	MED	OTHER INJURIES, POISONINGS & TOXIC EFF DIAG AGE <70 W/O CC	.6003	6.0	3.5	21

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
*** WEIGHT, LENGTH OF STAY, AND OUTLIER THRESHOLD ARE ESTIMATED; THEY WILL BE RECOMPUTED FOR FINAL.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

DRG	MDC		TITLE	RELATIVE WEIGHTS	ARITHMETIC MEAN LOS	GEOMETRIC MEAN LOS	OUTLIER THRESHOLD
456	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.8156	11.9	5.5	23
457	22	MED	***EXTENSIVE BURNS W/O O.R. PROCEDURE	3.9655	11.9	4.3	21
458	22	SURG	NON-EXTENSIVE BURNS WITH SKIN GRAFTS	3.9455	26.0	18.9	36
459	22	SURG	NON-EXTENSIVE BURNS WITH WOUND DEBRIDEMENT & OTHER O.R. PROC	3.2662	20.8	13.5	31
460	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	1.1595	11.2	7.5	25
461	23	SURG	O.R. PROC WITH DIAGNOSES OF OTHER CONTACT WITH HEALTH SERVICES	1.3572	10.2	5.3	22
462	23	MED	REHABILITATION	2.1408	24.2	18.0	35
463	23	MED	SIGNS & SYMPTOMS WITH CC	.7951	6.0	5.9	23
464	23	MED	SIGNS & SYMPTOMS W/O CC	.6948	7.6	5.0	22
465	23	MED	AFTERCARE WITH HISTORY OF MALIGNANCY AS SECONDARY DX	.2882	2.1	1.7	5
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DX	.4153	4.5	2.7	16
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.7223	7.9	3.9	21
468	*		UNRELATED OR PROCEDURE	2.4542	17.1	11.7	29
469		**	PDX INVALID AS DISCHARGE DIAGNOSIS	.0000		.0	0
470		**	UNGROUPABLE	.0000		.0	0
471	8	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF THE LOWER EXTREMI	3.6994	23.5	20.9	38
472	22	SURG	***EXTENSIVE BURNS WITH O.R. PROCEDURE	12.3012	35.4	23.1	40
473	17	MED	***ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE > 17	2.3234	13.6	7.5	25

* MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM MARYLAND AND MICHIGAN FOR LOW VOLUME DRGS.
** DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
*** WEIGHT, LENGTH OF STAY, AND OUTLIER THRESHOLD ARE ESTIMATED; THEY WILL BE RECOMPUTED FOR FINAL.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR OUTLIER AND TRANSFER CASES.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.
NOTE: ARITHMETIC MEAN INCLUDED FOR COMPARATIVE PURPOSES. IT IS NOT USED FOR PAYMENT.

TABLE 6 - CHANGES TO GROUPER PROGRAM

PROBLEM	GROUPER MODIFICATION
A. DRG Logic Issues	
DRG 385 (Neonates, Died or Transferred) includes transfers to foster care facilities, as well as other facilities, in addition to transfers to acute care hospitals. It is not appropriate to classify normal newborns transferred to foster care facilities, or similar facilities, into DRG 385.	Assign a newborn to DRG 385 only for cases with a reported discharge status of "died" or "transferred to an acute care hospital." Assign a newborn transferred to other than an acute care facility to DRGs 386-391, as appropriate, based on the diagnosis and procedure codes.
Procedure code 8421, thumb reattachment, had been inadvertently omitted from the procedures classified in MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue).	Add procedure code 8421 to DRGs 228 and 229.
B. SURGICAL HIERARCHY	
Cases showing multiple surgical procedures should be classified into the DRG that coincides with the most resource intensive procedure performed. Based upon the current weights:	
In MDC 2 (Diseases and Disorders of the Eye), extraocular procedures except orbit are more resource intensive than primary iris procedures.	1. Place extraocular procedures except orbit above primary iris procedures in the surgical hierarchy for MDC 2.
In MDC 3 (Diseases and Disorders of the Ear, Nose and Throat), cleft lip and palate repair and sinus and mastoid procedures, are more resource intensive than salivary gland procedures except sailoadenectomy.	2. Place cleft lip and palate repair and sinus and mastoid procedures above salivary gland procedures except sailoadenectomy in the surgical hierarchy for MDC 3.
In MDC 5 (Diseases and Disorders of the Circulatory System), permanent cardiac pacemaker implantations are more resource intensive than vascular procedures.	3. Place permanent cardiac pacemaker implantation above vascular procedures in the surgical hierarchy for MDC 5.
In MDC 6 (Diseases and Disorders of the Digestive System), mouth procedures are more resource intensive than anal and stomal procedures.	4. Place mouth procedures above anal and stomal procedures in the surgical hierarchy for MDC 6.

PROBLEM	GROUPER MODIFICATION
In MDC 7 (Diseases and Disorders of the Hepatobiliary System), diagnostic procedures are more resource intensive than biliary tract procedures.	5. Place diagnostic procedures above biliary tract procedures in the surgical hierarchy for MDC 7.
In MDC 21 (Injuries, Poisonings and Toxic Effect of Drugs), wound debridements are more resource intensive than skin grafts.	6. Place wound debridements above skin grafts in the surgical hierarchy for MDC 21.
C. Homogeneity	
In MDC 22 (Burns), cases assigned to DRG 457 show a high degree of heterogeneity. One of the factors contributing to this heterogeneity is the comingling of cases requiring surgical procedures with those treated medically.	DRG 457, extensive burns, would be divided into 2 categories. The new DRG 457 would include only extensive burns without O.R. procedures. A new DRG 472 would include extensive burns with O.R. procedures.
In MDC 17 (Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms), a high degree of heterogeneity exists in DRGs 401 through 404. Two factors have been identified as contributing to this heterogeneity, that is, comingling of acute leukemia with lymphoma and other leukemia cases and differentiating classification on the basis of age.	DRGS 401 through 405 would be reconfigured to remove acute leukemia cases. Acute leukemia without major O.R. procedure would be classified into 2 DRGs, that is, DRG 405 for patients under age 18 and a new DRG 473 for patients over age 17. Lymphoma/non-acute leukemia without major O.R. procedure would be classified based on other O.R. procedures, with and without CC, and medical cases, with and without CC. Age would no longer affect DRG classification of lymphoma/non-acute leukemia.

PROBLEM

In MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), the construction of DRGs 223-224, upper extremity O.R. procedures, results in the comingling of a broad range of procedures that can be performed on a single body site. There is substantial variability in resources associated with these procedures.

Also in MDC 8, the construction of DRGs 228-229, hand O.R. procedures, results in the comingling of a broad range of surgical procedures, with DRG assignment dependent only on the presence or absence of ganglion diagnoses. There is substantial variation in the resources associated with these procedures.

In MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract), it was found that age or absence of CC had little effect on the resource consumption associated with extracorporeal shock wave lithotripsy (ESWL). Regardless of patient age and the absence of complications or comorbidities, the procedure is similar in resources to those cases classified into DRG 323, urinary Stones, age greater than 69 and/or CC.

GROUPER MODIFICATION

DRGs 223-224 would be reconfigured to eliminate age considerations from this classification. Major shoulder and elbow joint procedures would be grouped to a single DRG. Other upper extremity O.R. procedures with CCs would be classified in the same DRG as major upper extremity joint procedures.

DRGs 228-229 would be reconfigured to eliminate ganglion diagnoses from consideration in the classification of hand procedures. Major wrist, hand and thumb O.R. procedures and other O.R. procedures with CC would be grouped to DRG 228. O.R. procedures other than major joint procedures without CC would comprise the proposed DRG 229.

All cases with a principal diagnosis of urinary stones that were treated with ESWL and no O.R. procedures would be assigned to DRG 323, regardless of age and/or CC.

TABLE 7 - MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY, FY 1984 DATA

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
001	20,282	21.4	7.0	10.0	16.0	27.0	42.0
002	4,277	19.6	4.0	8.0	14.0	25.0	40.0
003	3	7.7	1.0	1.0	1.5	4.3	18.0
004	4,029	20.2	6.0	9.0	15.0	25.0	40.0
005	54,235	9.6	4.0	5.0	8.0	12.0	18.0
006	12,944	2.7	1.0	2.0	2.0	3.0	5.0
007	7,810	11.5	2.0	3.0	5.0	13.0	27.0
008	4,042	5.6	1.0	2.0	3.0	6.0	12.0
009	3,311	14.4	2.0	4.0	8.0	16.0	31.0
010	17,887	11.5	2.0	4.0	8.0	15.0	24.0
011	3,740	10.1	2.0	3.0	6.0	12.0	21.0
012	51,764	11.3	3.0	5.0	8.0	13.0	23.0
013	7,656	10.8	2.0	5.0	9.0	14.0	21.0
014	306,936	12.6	3.0	5.0	9.0	15.0	25.0
015	172,533	6.1	2.0	3.0	5.0	8.0	11.0
016	19,142	8.8	3.0	4.0	7.0	11.0	17.0
017	22,292	7.7	2.0	3.0	6.0	9.0	15.0
018	27,455	8.2	2.0	4.0	6.0	10.0	16.0
019	9,686	7.1	2.0	3.0	5.0	9.0	14.0
020	6,314	11.5	2.0	4.0	8.0	15.0	24.0
021	557	10.5	3.0	5.0	8.0	13.0	20.0
022	13,107	6.5	2.0	3.0	5.0	8.0	12.0
023	4,813	8.4	1.0	3.0	6.0	10.0	18.0
024	53,445	6.8	2.0	3.0	5.0	8.0	13.0
025	20,369	5.4	1.0	2.0	4.0	7.0	11.0
026	53	3.8	1.0	1.0	2.0	6.0	8.7
027	2,119	9.7	1.0	1.0	5.0	11.0	24.0
028	10,131	8.4	1.0	2.0	5.0	10.0	18.0
029	1,549	6.0	1.0	2.0	3.0	7.0	13.0
031	10,214	5.6	1.0	2.0	4.0	7.0	12.0
032	2,337	4.0	1.0	2.0	3.0	5.0	8.0
034	14,957	8.9	2.0	3.0	6.0	11.0	18.0
035	4,020	7.6	2.0	3.0	5.0	9.0	16.0
036	19,243	4.7	2.0	3.0	4.0	6.0	8.0
037	4,235	4.2	2.0	2.0	3.0	5.0	6.0
038	3,395	3.0	1.0	2.0	2.0	3.0	6.0
039	411,667	2.2	1.0	2.0	2.0	2.0	3.0
040	16,075	2.4	1.0	2.0	2.0	3.0	4.0
042	25,809	3.7	2.0	2.0	3.0	4.0	7.0
043	569	4.6	2.0	2.0	4.0	6.0	8.0
044	2,520	7.2	3.0	4.0	6.0	9.0	13.0
045	5,482	4.7	2.0	2.0	4.0	6.0	9.0
046	6,479	5.5	1.0	2.0	4.0	7.0	12.0
047	16,838	3.6	1.0	1.0	2.0	4.0	7.0
049	5,257	17.1	5.0	9.0	14.0	21.0	32.0
050	5,050	4.4	2.0	3.0	4.0	5.0	7.0
051	1,165	3.9	2.0	2.0	3.0	5.0	7.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
052	49	4.4	1.0	2.0	4.0	5.0	7.0
053	9,376	3.7	1.0	2.0	3.0	4.0	7.0
055	16,090	2.6	1.0	2.0	2.0	3.0	4.0
056	3,407	2.7	1.0	2.0	2.0	3.0	5.0
057	839	5.6	1.0	2.0	3.0	7.0	13.0
059	456	2.8	1.0	2.0	2.0	3.0	5.0
061	711	2.9	1.0	1.0	2.0	3.0	6.0
063	4,818	8.1	2.0	3.0	5.0	10.0	18.0
064	13,029	8.4	1.0	2.0	5.0	10.0	19.0
065	44,337	4.7	2.0	2.0	4.0	6.0	9.0
066	14,575	4.2	1.0	2.0	4.0	5.0	8.0
067	323	6.4	2.0	3.0	5.0	8.0	12.0
068	34,639	6.2	2.0	3.0	5.0	8.0	11.0
069	6,698	5.0	2.0	3.0	4.0	6.0	9.0
070	24	4.1	1.0	3.0	3.0	4.0	8.0
071	206	5.8	2.0	3.0	5.0	7.0	11.0
072	1,740	5.1	1.0	2.0	3.0	7.0	11.0
073	14,743	5.0	1.0	2.0	3.0	6.0	11.0
075	27,103	16.2	7.0	9.0	14.0	20.0	29.0
076	10,212	14.8	3.0	6.0	11.0	19.0	30.0
077	4,692	11.4	2.0	3.0	8.0	15.0	25.0
078	27,908	11.7	4.0	8.0	11.0	14.0	20.0
079	44,827	13.0	3.0	6.0	10.0	16.0	25.0
080	2,897	12.1	3.0	5.0	9.0	14.0	23.0
082	124,736	9.8	2.0	4.0	7.0	13.0	21.0
083	10,709	8.5	3.0	4.0	7.0	11.0	16.0
084	1,037	6.0	2.0	3.0	5.0	8.0	12.0
085	19,396	9.9	2.0	4.0	8.0	12.0	19.0
086	1,857	8.8	2.0	3.0	6.0	10.0	18.0
087	82,939	10.1	2.0	4.0	8.0	12.0	20.0
088	221,875	8.5	3.0	4.0	7.0	10.0	16.0
089	302,582	9.6	3.0	5.0	8.0	12.0	17.0
090	25,293	7.7	3.0	4.0	6.0	9.0	14.0
091	34	5.6	1.0	3.0	4.0	7.0	11.6
092	15,396	9.0	2.0	4.0	7.0	11.0	17.0
093	2,266	7.5	2.0	3.0	6.0	9.0	14.0
094	7,929	10.1	3.0	5.0	8.0	13.0	20.0
095	1,073	7.8	2.0	4.0	6.0	9.0	14.7
096	173,106	7.2	3.0	4.0	6.0	9.0	13.0
097	31,481	6.1	2.0	3.0	5.0	8.0	11.0
098	15	4.5	2.0	2.0	3.5	6.0	7.5
099	41,200	6.4	2.0	3.0	5.0	8.0	13.0
100	8,999	4.9	1.0	2.0	4.0	6.0	10.0
101	30,746	7.4	2.0	3.0	6.0	9.0	14.0
102	4,491	6.0	1.0	2.0	4.0	7.0	12.0
103	12	36.0	3.2	15.0	27.0	46.0	54.8
104	3,007	20.9	10.0	13.0	18.0	25.0	35.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
105	10,485	18.2	9.0	11.0	15.0	22.0	32.0
106	18,059	16.2	9.0	11.0	14.0	19.0	25.0
107	40,965	14.5	8.0	10.0	12.0	17.0	24.0
108	837	14.6	3.0	8.0	12.0	18.0	28.0
109	4,614	14.7	1.0	5.0	11.0	19.0	31.0
110	53,424	16.3	7.0	10.0	13.0	19.0	29.0
111	10,460	13.1	6.0	9.0	11.0	15.0	21.0
112	44,075	11.7	2.0	5.0	9.0	15.0	24.0
113	28,235	21.7	8.0	11.0	17.0	27.0	41.0
114	8,206	17.2	4.0	7.5	13.0	22.0	34.0
115	7,858	16.6	7.0	10.0	14.0	20.0	28.0
116	51,778	9.5	3.0	5.0	8.0	12.0	17.0
117	5,238	6.4	2.0	3.0	5.0	8.0	13.0
118	8,312	4.6	1.0	2.0	3.0	5.0	9.0
119	5,751	7.6	2.0	3.0	5.0	9.0	16.0
120	19,661	16.9	3.0	7.0	12.0	22.0	35.0
121	94,297	12.3	5.0	8.0	11.0	15.0	21.0
122	162,222	10.6	4.0	7.0	10.0	13.0	17.0
123	67,722	5.6	1.0	1.0	3.0	7.0	14.0
124	23,861	7.0	2.0	2.0	5.0	9.0	15.0
125	54,303	3.8	1.0	2.0	2.0	4.0	8.0
126	2,725	23.8	5.0	12.0	22.0	33.0	43.0
127	499,497	8.8	3.0	4.0	7.0	11.0	17.0
128	41,834	9.8	4.0	6.0	9.0	12.0	16.0
129	17,078	7.9	1.0	1.0	4.0	10.0	19.0
130	97,485	8.3	2.0	3.0	6.0	11.0	16.0
131	18,882	6.6	1.0	2.0	5.0	9.0	13.0
132	123,150	7.0	2.0	3.0	5.0	9.0	13.0
133	20,211	5.2	2.0	2.0	4.0	7.0	10.0
134	77,824	6.6	2.0	3.0	5.0	8.0	12.0
135	16,878	7.2	2.0	3.0	5.0	9.0	14.0
136	3,128	5.6	2.0	2.0	4.0	6.0	11.0
138	204,931	6.4	2.0	3.0	5.0	8.0	12.0
139	29,480	5.1	1.0	2.0	4.0	6.0	10.0
140	309,903	5.7	2.0	3.0	5.0	7.0	10.0
141	83,647	5.7	2.0	3.0	4.0	7.0	11.0
142	11,678	4.6	1.0	2.0	4.0	6.0	9.0
143	75,589	4.4	1.0	2.0	4.0	5.0	8.0
144	38,367	8.3	2.0	4.0	7.0	11.0	16.0
145	16,670	7.0	2.0	3.0	5.0	9.0	14.0
146	15,328	18.8	10.0	12.0	16.0	22.0	31.0
147	2,232	15.3	9.0	11.0	14.0	18.0	24.0
148	103,604	17.7	9.0	11.0	15.0	21.0	30.0
149	12,131	14.3	8.0	9.0	12.0	16.0	23.0
150	15,303	14.9	7.0	9.0	12.0	18.0	26.0
151	2,883	11.5	6.0	8.0	10.0	14.0	19.0
152	11,160	10.8	3.0	6.0	9.0	13.0	19.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
153	2,720	9.0	3.0	5.0	8.0	11.0	15.0
154	52,970	15.0	4.0	7.0	12.0	19.0	29.0
155	8,622	11.6	4.0	6.0	9.0	14.0	21.0
157	38,564	6.4	2.0	3.0	5.0	8.0	13.0
158	16,226	4.8	2.0	3.0	4.0	6.0	9.0
159	20,736	7.8	3.0	4.0	6.0	9.0	14.0
160	9,018	5.9	2.0	3.0	5.0	7.0	10.0
161	82,802	5.3	2.0	3.0	4.0	6.0	9.0
162	30,103	4.0	2.0	3.0	4.0	5.0	7.0
163	23	5.5	1.3	2.8	4.0	6.0	9.7
164	4,560	12.1	6.0	8.0	10.0	14.0	20.0
165	1,230	9.2	5.0	6.0	8.0	11.0	14.0
166	3,376	9.0	4.0	5.0	7.0	11.0	16.0
167	1,617	6.0	3.0	4.0	5.0	7.0	10.0
168	9,316	6.1	2.0	2.0	3.0	7.0	14.0
169	3,976	4.0	1.0	2.0	3.0	4.0	8.0
170	13,655	17.6	4.0	8.0	13.0	22.0	35.0
171	2,573	15.4	3.0	5.0	10.0	18.0	34.0
172	57,435	10.4	2.0	4.0	7.0	13.0	22.0
173	6,754	9.2	1.0	3.0	5.0	11.0	20.0
174	135,839	7.5	2.0	4.0	6.0	9.0	14.0
175	16,456	5.9	2.0	3.0	5.0	7.0	10.0
176	11,186	8.2	2.0	4.0	6.0	10.0	16.0
177	34,864	6.6	2.0	4.0	5.0	8.0	12.0
178	8,904	5.4	2.0	3.0	5.0	7.0	10.0
179	8,593	9.6	3.0	4.0	7.0	12.0	19.0
180	62,701	7.3	2.0	3.0	6.0	9.0	14.0
181	9,417	5.8	2.0	3.0	5.0	7.0	11.0
182	381,615	6.0	2.0	3.0	5.0	7.0	11.0
183	77,959	5.0	2.0	3.0	4.0	6.0	9.0
184	62	3.6	1.0	1.5	2.0	4.0	7.8
185	8,693	6.5	1.0	2.0	4.0	8.0	14.0
186	3	3.0	2.0	2.0	2.0	2.3	5.0
187	5,980	2.8	1.0	2.0	2.0	3.0	5.0
188	55,543	6.4	1.0	2.0	4.0	8.0	13.0
189	12,857	4.8	1.0	2.0	3.0	6.0	10.0
190	173	6.1	1.0	3.0	4.0	7.0	12.0
191	4,093	21.9	9.0	12.0	18.0	28.0	40.0
192	1,820	21.7	7.0	11.0	17.0	26.0	43.0
193	10,600	18.4	8.0	11.0	16.0	22.0	31.0
194	1,136	15.0	6.0	9.0	12.0	18.0	27.0
195	18,890	14.5	8.0	10.0	13.0	17.0	23.0
196	1,356	11.1	7.0	8.0	10.0	13.0	17.0
197	71,078	11.9	6.0	8.0	10.0	14.0	20.0
198	20,292	8.7	5.0	6.0	8.0	10.0	14.0
199	4,256	17.3	6.0	10.0	15.0	22.0	31.0
200	3,352	15.8	3.0	7.0	12.0	20.0	33.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
201	2,691	16.0	2.0	6.0	12.0	22.0	33.0
202	20,624	10.7	3.0	5.0	8.0	14.0	22.0
203	36,494	10.1	2.0	4.0	7.0	13.0	21.0
204	30,552	8.2	3.0	4.0	7.0	10.0	15.0
205	22,307	9.4	2.0	4.0	7.0	12.0	19.0
206	4,406	7.5	2.0	3.0	5.0	9.0	15.0
207	56,444	7.0	2.0	3.0	6.0	9.0	13.0
208	9,961	5.1	2.0	3.0	4.0	6.0	9.0
209	141,214	15.8	9.0	11.0	14.0	18.0	24.0
210	115,730	16.9	8.0	11.0	14.0	19.0	27.0
211	8,676	15.0	7.0	9.0	13.0	17.0	25.0
212	12	9.7	4.2	6.0	7.0	10.0	11.0
213	4,427	17.0	4.0	7.0	13.0	21.0	35.0
214	24,741	15.6	7.0	9.0	13.0	19.0	28.0
215	15,769	11.9	5.0	7.0	10.0	15.0	21.0
216	4,447	13.7	2.0	4.0	10.0	18.0	30.0
217	6,284	18.7	2.0	5.0	13.0	25.0	43.0
218	16,388	11.2	4.0	6.0	9.0	14.0	21.0
219	7,768	8.1	3.0	5.0	7.0	10.0	15.0
220	6	5.7	1.0	1.5	5.0	6.5	9.4
221	12,284	7.0	2.0	2.0	4.0	9.0	15.0
222	9,349	4.6	1.0	2.0	3.0	6.0	10.0
223	11,178	7.1	2.0	3.0	5.0	9.0	14.0
224	6,172	5.2	2.0	3.0	4.0	6.0	10.0
225	34,552	4.8	2.0	3.0	4.0	5.0	8.0
226	6,628	8.1	2.0	3.0	5.0	10.0	18.0
227	4,073	5.2	2.0	2.0	4.0	6.0	11.0
228	876	2.2	1.0	1.0	2.0	3.0	3.0
229	15,560	3.9	1.0	2.0	3.0	4.0	8.0
230	5,184	9.2	2.0	3.0	6.0	11.0	20.0
231	12,807	5.6	1.0	2.0	3.0	6.0	12.0
232	2,996	4.5	1.0	2.0	3.0	5.0	10.0
233	11,026	11.5	3.0	5.0	9.0	14.0	23.0
234	4,026	7.5	2.0	3.0	5.0	9.0	15.0
235	7,302	17.9	2.0	5.0	11.0	21.0	44.0
236	46,967	13.0	2.0	5.0	10.0	16.0	25.0
237	3,286	7.3	2.0	3.0	6.0	9.0	14.0
238	4,765	15.8	4.0	7.0	11.0	20.0	33.0
239	58,837	10.5	3.0	5.0	8.0	13.0	20.0
240	24,082	9.5	3.0	5.0	7.0	12.0	18.0
241	8,811	8.1	2.0	4.0	6.0	10.0	15.0
242	2,224	13.4	3.0	6.0	10.0	17.0	28.6
243	205,931	8.0	2.0	4.0	7.0	10.0	15.0
244	43,473	7.9	2.0	4.0	6.0	10.0	15.0
245	7,159	6.7	2.0	3.0	5.0	8.0	13.0
246	6,441	6.9	2.0	3.0	5.0	8.0	13.0
247	17,387	6.3	2.0	3.0	5.0	8.0	12.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
248	12,011	6.3	2.0	3.0	5.0	8.0	12.0
249	6,162	8.8	1.0	3.0	6.0	11.0	19.0
250	15,701	5.5	1.0	2.0	4.0	7.0	12.0
251	3,797	3.5	1.0	1.0	2.0	4.0	7.0
253	44,409	7.7	2.0	3.0	6.0	10.0	15.0
254	9,265	5.7	1.0	2.0	4.0	7.0	12.0
255	4	4.8	1.0	1.0	1.0	3.0	14.0
256	14,906	7.2	2.0	3.0	5.0	9.0	15.0
257	32,093	8.6	5.0	6.0	8.0	10.0	14.0
258	7,697	7.5	4.0	5.0	7.0	9.0	11.0
259	7,432	7.0	2.0	3.0	5.0	9.0	15.0
260	1,775	4.7	1.0	2.0	3.0	6.0	9.0
261	6,710	4.1	2.0	2.0	3.0	5.0	8.0
262	15,198	2.7	1.0	2.0	2.0	3.0	5.0
263	16,404	22.1	6.0	10.0	17.0	28.0	44.0
264	3,056	21.7	4.0	8.0	16.0	28.0	46.0
265	4,312	11.6	2.0	4.0	8.0	15.0	25.0
266	10,461	6.1	1.0	2.0	4.0	8.0	13.0
267	830	5.4	2.0	3.0	4.0	6.0	11.0
268	3,475	3.8	1.0	2.0	3.0	4.0	8.0
269	19,468	9.5	2.0	2.0	5.0	11.0	22.0
270	7,282	6.3	1.0	2.0	3.0	7.0	14.0
271	24,770	14.1	4.0	6.0	10.0	16.0	27.0
272	13,637	9.5	3.0	5.0	7.0	11.0	19.0
273	2,629	9.3	2.0	4.0	7.0	11.0	20.1
274	14,248	10.9	2.0	4.0	7.0	14.0	24.0
275	2,430	10.4	1.0	3.0	6.0	11.5	25.0
276	2,619	5.3	1.0	2.0	3.0	6.0	11.0
277	56,605	9.2	3.0	5.0	7.0	11.0	16.0
278	11,859	7.9	3.0	4.0	6.0	9.0	14.0
279	9	8.6	2.0	2.3	3.0	4.8	21.1
280	38,047	6.4	2.0	3.0	5.0	8.0	13.0
281	5,620	4.7	1.0	2.0	3.0	6.0	10.0
282	4	2.0	1.0	1.0	1.0	2.0	4.0
283	16,120	7.0	2.0	3.0	5.0	9.0	14.0
284	4,169	5.3	1.0	2.0	4.0	7.0	11.0
285	1,666	27.9	8.0	14.0	22.0	36.0	55.0
286	1,010	15.7	7.0	9.0	12.0	19.0	29.0
287	2,886	21.4	6.0	9.0	16.0	27.0	42.4
288	546	12.4	5.0	7.0	9.0	13.5	24.4
289	2,520	8.7	3.0	4.0	6.0	10.0	18.0
290	8,246	5.9	3.0	4.0	5.0	6.0	10.0
291	195	4.1	2.0	3.0	3.0	5.0	7.0
292	3,954	16.7	3.0	6.0	12.0	21.0	34.0
293	753	13.9	2.0	3.3	9.0	17.0	32.0
294	127,436	8.2	3.0	5.0	7.0	10.0	15.0
295	2,455	6.7	2.0	3.0	5.0	9.0	13.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
296	159,997	8.3	2.0	4.0	6.0	10.0	16.0
297	12,874	7.0	2.0	3.0	5.0	8.0	13.0
298	46	5.3	1.0	2.0	3.0	5.0	8.4
299	1,622	7.6	2.0	3.0	5.0	9.0	15.0
300	15,767	9.2	3.0	4.0	7.0	11.0	18.0
301	3,235	6.9	2.0	3.0	5.0	8.0	13.0
302	3,960	24.5	11.0	15.0	21.0	29.0	42.0
303	11,723	16.5	8.0	10.0	14.0	20.0	28.0
304	17,686	13.4	5.0	8.0	11.0	17.0	24.0
305	5,513	10.3	4.0	6.0	9.0	12.0	18.0
306	21,487	9.8	4.0	5.0	8.0	12.0	18.0
307	3,182	7.6	3.0	5.0	6.0	9.0	13.0
308	14,180	8.7	2.0	3.0	6.0	11.0	18.0
309	2,885	6.6	2.0	2.0	5.0	9.0	14.0
310	52,714	5.6	2.0	3.0	4.0	7.0	11.0
311	11,827	4.1	1.0	2.0	3.0	5.0	7.0
312	7,743	5.8	2.0	3.0	4.0	7.0	11.0
313	1,911	4.6	2.0	2.0	3.0	6.0	9.0
314	5	6.8	2.0	2.3	6.5	8.0	8.5
315	15,174	15.3	3.0	5.0	10.0	20.0	33.0
316	46,176	10.0	2.0	3.0	7.0	13.0	21.0
317	1,137	3.3	1.0	1.0	2.0	4.0	7.0
318	17,907	8.8	2.0	3.0	6.0	11.0	19.3
319	2,673	6.6	1.0	2.0	3.0	7.0	15.0
320	136,650	8.1	3.0	4.0	7.0	10.0	15.0
321	15,809	6.4	2.0	3.0	5.0	8.0	11.0
322	47	6.3	2.0	3.0	6.0	7.0	10.0
323	28,701	5.1	1.0	2.0	4.0	6.0	10.0
324	11,450	3.6	1.0	2.0	3.0	4.0	7.0
325	29,447	6.5	2.0	3.0	5.0	8.0	13.0
326	4,871	4.9	1.0	2.0	3.0	6.0	10.0
327	16	28.6	1.0	2.0	2.0	3.0	6.4
328	7,366	5.3	2.0	2.0	4.0	7.0	11.0
329	1,377	4.1	1.0	2.0	3.0	5.0	8.0
331	41,532	7.6	2.0	3.0	6.0	10.0	15.0
332	7,601	6.0	1.0	2.0	4.0	7.0	12.0
333	112	5.8	1.0	2.0	3.0	7.0	13.8
334	7,300	13.5	8.0	9.0	12.0	16.0	21.0
335	7,674	11.9	7.0	9.0	11.0	14.0	18.0
336	141,454	7.9	4.0	5.0	7.0	9.0	13.0
337	28,122	6.2	4.0	5.0	6.0	7.0	9.0
338	9,221	7.3	2.0	3.0	4.0	10.0	16.0
339	9,687	4.3	2.0	2.0	3.0	5.0	8.0
340	5	2.6	1.0	1.3	2.0	2.8	3.5
341	12,243	6.3	3.0	4.0	5.0	8.0	11.0
342	3,600	2.9	1.0	2.0	2.0	3.0	6.0
344	4,905	8.3	2.0	4.0	7.0	10.0	15.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
345	4,373	6.5	2.0	3.0	5.0	8.0	13.0
346	29,576	8.4	2.0	3.0	6.0	10.0	18.0
347	3,556	5.8	1.0	2.0	3.0	7.0	13.0
348	23,457	5.6	1.0	2.0	4.0	7.0	11.0
349	5,804	3.8	1.0	2.0	2.0	5.0	8.0
350	11,803	5.9	2.0	3.0	5.0	7.0	11.0
351	12	1.8	1.0	1.0	1.0	2.0	2.0
352	2,503	4.8	1.0	2.0	3.0	6.0	10.0
353	2,204	14.0	4.0	7.0	11.0	18.0	27.0
354	29,643	9.6	6.0	7.0	8.0	11.0	15.0
355	15,441	7.8	5.0	6.0	7.0	9.0	11.0
356	24,712	7.6	4.0	5.0	7.0	9.0	12.0
357	2,907	14.8	6.0	8.0	12.5	18.0	26.0
358	4,602	8.5	2.0	5.0	7.0	11.0	15.0
359	183	3.3	1.0	2.0	3.0	4.0	6.0
360	8,528	4.8	1.0	2.0	3.0	6.0	10.0
361	674	4.8	1.0	2.0	3.0	6.0	11.0
362	114	2.0	1.0	1.0	2.0	2.0	3.0
363	8,394	4.9	2.0	2.0	3.0	5.0	10.0
364	18,418	2.8	1.0	2.0	2.0	3.0	5.0
365	3,850	14.0	5.0	7.0	11.0	18.0	27.0
366	14,608	8.3	1.0	2.0	5.0	10.0	20.0
367	3,947	4.6	1.0	1.0	2.0	5.0	10.0
368	1,899	7.7	2.0	4.0	6.0	9.0	14.0
369	8,417	5.5	1.0	2.0	4.0	7.0	11.0
370	196	7.9	4.0	5.0	6.0	8.0	13.0
371	417	6.1	4.0	4.0	5.0	6.0	8.0
372	163	5.1	2.0	3.0	4.0	6.0	9.0
373	1,213	3.1	2.0	2.0	3.0	4.0	5.0
374	155	3.7	2.0	3.0	3.0	4.0	5.0
375	4	10.0	3.0	3.0	6.0	11.0	20.0
376	73	4.9	1.0	2.0	3.0	5.0	8.7
377	23	4.3	1.0	2.0	3.5	6.3	7.7
378	66	5.1	2.0	3.0	5.0	5.0	9.0
379	115	2.6	1.0	1.0	2.0	3.0	5.0
380	114	2.8	1.0	1.0	2.0	3.0	6.0
381	279	2.0	1.0	1.0	2.0	2.0	4.0
382	97	1.5	1.0	1.0	1.0	1.0	2.0
383	417	4.8	1.0	2.0	3.0	6.0	9.0
384	101	4.3	1.0	1.0	2.0	4.8	9.0
385	83	18.6	1.0	3.0	12.0	28.3	52.0
386	65	15.4	3.0	5.0	8.5	16.8	24.5
389	323	14.7	2.0	5.0	9.0	16.0	35.0
390	250	10.4	2.0	3.0	7.0	14.0	20.0
391	26	20.1	1.0	2.5	7.0	22.5	48.0
392	1,839	17.3	7.0	9.0	14.0	22.0	33.0
394	3,217	8.0	2.0	2.0	5.0	10.0	18.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
395	92,467	6.7	1.0	3.0	5.0	8.0	13.0
396	44	1.7	1.0	1.0	1.0	2.0	2.6
397	9,302	8.3	2.0	4.0	6.0	10.0	16.0
398	11,744	8.1	2.0	3.0	6.0	10.0	17.0
399	1,904	6.4	1.0	2.0	4.0	8.0	14.0
400	6,271	16.7	5.0	8.0	13.0	21.0	33.0
401	9,757	12.2	2.0	4.0	9.0	16.0	26.3
402	2,360	8.1	2.0	3.0	6.0	10.0	17.0
403	54,077	10.6	2.0	3.0	7.0	14.0	24.0
404	9,753	8.4	1.0	2.0	5.0	10.0	20.0
406	3,461	16.7	5.0	8.3	14.0	22.0	32.0
407	2,749	13.0	2.0	5.0	9.0	16.0	26.0
408	10,867	8.3	2.0	3.0	5.0	10.0	19.0
409	6,899	10.8	2.0	4.0	7.0	15.0	24.0
410	72,946	3.1	1.0	1.0	2.0	4.0	6.0
411	4,640	5.8	1.0	2.0	4.0	7.0	13.0
412	3,652	2.3	1.0	1.0	2.0	2.0	4.0
413	24,347	10.7	2.0	4.0	7.0	14.0	23.0
414	4,223	9.1	1.0	3.0	5.0	11.0	21.0
415	14,235	20.4	5.0	9.0	15.0	26.0	41.0
416	59,603	11.7	2.0	6.0	9.0	14.0	22.0
417	20	7.5	1.0	3.0	6.0	11.0	12.0
418	8,991	9.7	3.0	5.0	8.0	12.0	18.0
419	17,231	8.3	2.0	4.0	6.0	10.0	15.0
420	2,738	7.5	2.0	3.0	5.0	9.0	14.0
421	17,172	5.7	2.0	3.0	5.0	7.0	11.0
422	53	5.2	1.0	2.0	3.0	6.0	8.7
423	8,966	10.9	3.0	5.0	8.0	13.0	21.0
424	5,169	22.1	4.0	8.0	16.0	28.0	46.0
425	16,950	7.5	2.0	3.0	5.0	8.0	16.0
426	28,185	11.7	3.0	4.0	8.0	14.0	26.0
427	3,146	9.7	2.0	3.0	6.0	12.0	21.0
428	2,270	11.9	2.0	4.0	8.0	14.0	25.0
429	50,326	11.0	3.0	4.0	8.0	13.0	22.0
430	84,937	15.4	3.0	6.0	11.0	20.0	32.0
431	726	10.3	2.0	3.0	7.0	12.0	22.2
432	1,173	8.0	1.0	2.0	5.0	10.0	18.0
433	1,673	4.4	1.0	1.0	3.0	5.0	11.0
434	6,680	8.2	1.0	3.0	6.0	10.0	18.0
435	31,546	10.1	2.0	4.0	6.0	14.0	23.4
436	1,578	14.1	2.0	5.0	12.0	22.0	28.0
437	607	18.9	4.0	9.0	21.0	27.0	30.0
439	1,558	15.4	2.0	4.0	10.0	20.0	36.0
440	2,852	15.7	2.0	4.0	10.0	20.0	36.8
441	1,315	4.5	1.0	1.0	2.0	5.0	10.0
442	33,214	10.4	1.4	3.0	6.0	14.0	24.0
443	8,508	9.4	1.0	3.0	6.0	12.0	21.0

DRG NUMBER	NUMBER OF DISCHARGES	ARITHMETIC MEAN LOS	PERCENTILES				
			10TH	25TH	50TH	75TH	90TH
444	8,685	7.6	2.0	3.0	6.0	9.0	15.0
445	1,751	6.2	1.0	2.0	4.0	7.0	12.0
447	2,898	4.0	1.0	2.0	3.0	5.0	8.0
449	40,935	6.4	2.0	3.0	5.0	8.0	12.0
450	8,716	5.1	1.0	2.0	3.0	6.0	10.0
451	10	4.9	1.0	1.0	3.0	7.5	8.0
452	21,724	7.0	1.0	3.0	5.0	8.0	15.0
453	6,516	6.5	1.0	2.0	4.0	8.0	14.0
454	5,850	7.5	1.0	2.0	5.0	9.0	16.0
455	806	5.9	1.0	2.0	3.0	7.0	13.0
456	145	11.9	1.0	2.0	5.0	13.8	27.5
457	352	22.0	1.0	2.0	12.0	29.0	54.8
458	1,680	25.9	6.0	11.0	20.0	35.0	52.0
459	787	20.8	4.0	8.0	14.0	26.0	45.0
460	3,856	11.1	2.0	4.0	8.0	14.0	22.0
461	8,257	10.2	1.0	2.0	5.0	12.0	24.0
462	3,284	24.2	6.0	11.0	20.0	32.0	46.0
463	12,267	8.0	2.0	4.0	6.0	10.0	16.0
464	11,288	7.8	2.0	3.0	5.0	8.0	15.0
465	3,454	2.0	1.0	1.0	2.0	2.0	3.0
466	4,325	4.4	1.0	1.0	2.0	5.0	10.0
467	17,011	7.8	1.0	2.0	3.0	8.0	16.0
468	161,061	17.1	3.0	7.0	13.0	21.0	35.0
471	1,664	23.5	12.0	15.0	21.0	28.0	38.0

TECHNICAL NOTE: The above lengths of stay were developed using the same FY 1984 discharges and GROUPER program used to compute the recalibrated DRG relative weights which appeared in the September 3, 1985 Federal Register (50 FR 35722). Each percentile length of stay (LOS) value was computed according to the following formula:

Let n represent the number of discharges classified by DRG and let $x_1, x_2, \ldots, x_n$ represent the ordered LOS values for each DRG set of discharges. For the t_{th} percentile, where $p = t/100$, let $np = j + g$ where j is the integer part and g is the fractional part of np. The t_{th} percentile, y, is defined as the LOS value at x_{np}

$$y = (1-g)x_j + gx_{j+1}$$

(See SAS User's Guide: Basics, Version 5 Edition, Cary, NC: SAS Institute Inc., 1985, p. 1186)

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Appendix A—Data Sources Used to Estimate the Market Basket Relative Weights, and Choice of Price Proxies

As discussed above in section III of the preamble, we are proposing to rebase and reweight the hospital market basket. The market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. Below we list the data sources used to estimate the relative weights in the hospital market basket and our choice of price proxies.

A. Data Sources Used to Estimate Relative Weights

1. Payroll Expenses: Wages and Salaries

Source: American Hospital Association, *Hospital Statistics,* Annual Survey, Chicago, Illinois, 1983.

2. Payroll Expenses: Employee Benefits

Source: Same as above.

3. Professional Fees

Source: Same as above.

This category was split into two components:

- Medical fees; and
- Other professional fees. Medical professional fees comprise the largest portion of the professional fees component in the AHA *Annual Survey* of hospital costs. The weight for medical fees was calculated as a residual. The latter weight for other professional fees was derived from an analysis of the value of input consumption by the hospital industry as published in "The Detailed Input-Output Structure of the U.S. Economy: 1977," compiled by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce.[1] This weight was then subtracted from professional fees, resulting in the weight for medical professional fees.

4. Capital-Related Costs: Depreciation

Source: Same as above.

This item split into two asset components: (1) buildings and fixed equipment, and (2) moveable equipment, using unpublished data obtained from AHA.

5. Capital-Related Costs: Interest

Source: Same as above.

6. Capital-Related Costs: Other

This category consists of three components that are captured in the AHA classification "Residual-other expense," category. These components are—

- Fire and allied insurance;
- Leases and rentals; and
- Real estate taxes.

Under section 1886(a)(4) of the Act, Medicare providers are entitled to a "pass-through" reimbursement for these costs, as well as capital, depreciation and interest, for cost reporting periods beginning prior to October 1, 1986. In this proposed rule, this category would be included under the capital component of the hospital market basket.

The share for each cost is represented in the AHA residual expense category "Other" derived from an analysis of the value of input consumption by the hospital industry as published in "The Detailed Input-Output Structure of the U.S. Economy: 1977," compiled by BEA, U.S. Department of Commerce. The capital-related shares are combined into a single "Other capital-related" category and incorproated with the weights for depreciation and interest to form the aggregate capital component.

7. Utility and Energy Consumption

Source: Same as above.

This item was split into five cost components: (1) fuel, oil, coal and other fuel; (2) electricity; (3) natural gas; (4) motor gasoline; and (5) water and sewerage. The proportions of each cost were derived from an analysis of the value of input consumption by the hospital industry, as published in "The Detailed Input-Output Structure of the U.S. Economy: 1977," compiled by BEA.[2]

8. Malpractice Insurance

This cost category was derived from an analysis of the median percentage of professional liability insurance expense applied to total hospital insurance costs, as compiled in the *HAS/MONITREND Six-Month National Data Book,* published by the Hospital Administrative Service Division of AHA. The data from the six months ending June 30, 1982, and December 31, 1982, were combined and a weighted average based on bed-size was computed.

9. All Other Products and Services

This residual measures the weights of unattributed products and services included in the residual "Other" category published in the AHA Annual Survey. Shares were derived from an analysis of BEA's hospital input-output matrix and incorporates all noncapital-related categories (other capital-related shares was initially derived with the other residual costs shares and then incorporated into the capital component of the hospital market basket) consumed by the hospital industry, with the exception of utilities and energy consumption, malpractice insurance premiums, salaried and fee-paid other professional remuneration that were delineated above. The following major classifications were derived by aggregating like products and services consumed by the hospital industry:

Other Products

1. Pharmaceuticals.
2. Food.
   a. Direct Purchases.
   b. Indirect Purchases (by dietary contractors).
3. Chemical and Cleaning Products.
4. Surgical and Medical Instruments.
5. Photographic Supplies.
6. Rubber and Plastics.
7. Paper Products.
8. Apparel.
9. Minor Machinery and Equipment.
10. Miscellaneous Products.

Other Services

1. Business Services.
2. Computer and Data Processing Services.
3. Transportation and Shipping.
4. Telephone.
5. Blood Services.
6. Postage.
7. All Other Services: Labor-Intensive.
8. All Other Services: Nonlabor-Intensive.

B. Choice of Price Proxies

1. Payroll Expenses (Wages and Salaries)

External Wage Variable (used in Reimbursement Price Index)—Percentage change in weighted average of nine employment cost indexes and the internal wage variable, as described below.

Data Source—Department of Labor, Bureau of Labor Statistics, *Employment and Earnings.*

Frequency—Monthly.

Payroll expenses (wages and salaries) include all expenses defined as payroll by the AHA in their annual survey. Remuneration for salaried physicians, residents, and interns is included in payroll expenses, while remuneration for physicians who bill the hospital for their fees is not. Their fees are included in the cost category "professional fees, medical." For purposes of establishing the 1982 base-year weights,

[1] The Interindustry Economics Division of BEA conducts a survey of the value of input consumption by major industry classification at five-year intervals. The last study was for cost consumption during 1977. The calculated cost of each individual input goods and services supplied to the hospital industry was aged and updated from 1977 to 1982 using appropriate historical price movements for the detailed expense categories. Relative expenditure weights were then computed for the various cost categories.

[2] Ibid.

expenditures for trainees and residents and interns are removed.

In order to construct an external occupation-specific measure of hospital wages and salaries, occupational data were derived from a survey by the U.S. Census Bureau Survey of employment by the hospital industry published in the *1980 Census of Population, Subject Report, Occupation of Industry* in May 1984. The survey reported the number of employees in 1980 and the mean 1979 earnings of each of these occupations. Earnings and employment levels were combined to yield total payroll (wages and salaries) costs for nine occupational categories that can be measured by a corresponding Employment Cost Index (ECI). The ECI maintains a series on the level of wages and salaries paid to private industry workers in each of these occupational groups. Total payroll for each occupation in 1979 was then updated to 1982 by using the change in the corresponding ECI. Weights for each catgegory were calculated. By calculating a weighted average of price changes for each occupation, an external wage variable was constructed that associates the employment structure of the hospital industry with a reasonable measure of wage movements.

The following table describes the 1982 labor cost shares for wages and salaries paid employees of the hospital industry per ECI occupational groups.

TABLE—ECI OCCUPATIONAL GROUPS

	1982 wage cost shares (percent)
1. Professional/Technical	57.239
2. Managers/Administrators	7.248
3. Sales Workers	.337
4. Clerical Workers	12.537
5. Craft/Kindred Workers	2.461
6. Operatives, Except Transport	.994
7. Transport Equipment Operatives	.265
8. Nonfarm Workers	.196
9. Service Workers	18.723
Total	100.000

2. Employee Benefits

External Price Variable (used in Reimbursement Price Index)—Percentage change in supplements to wages and salaries per employee on nonagricultural payrolls.

Data Sources—

For supplements to wages and salaries—U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business.* July issues have details on components.

For number of employees on nonagricultural payrolls—U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings.*

Frequency—For supplements to wages and salaries, quarterly; for number of employees on nonagricultural payrolls, monthly.

Employee benefits include employer-paid fringe benefits for Social Security, group insurance, retirement, and other fringe benefits. Supplements to wages and salaries have two major categories of benefits:

- Employer contributions for social insurance; and
- Employer contributions to private pension and welfare funds. Employer contributions for social insurance include Federal, State, and local social insurance funds. These funds are for old-age, survivors, disability, and hospital insurance; State unemployment insurance; workmen's compensation; and other programs. Employer contributions to private pension and welfare funds include pension and profit-sharing, group health insurance, group life insurance, workmen's compensation, and supplemental unemployment. Supplements to wages and salaries include an irrelevant third component, "Other," which was approximately 0.7 percent of the total in 1982.

In calendar year 1982, employee benefits were 15.2 percent of community hospital employee compensation.[3] For total nonfarm, supplements to wages and salaries were 16.0 percent of employee compensation, and for all domestic industries supplements to wages and salaries were 15.9 percent of employee compensation in 1982.[4] The percent change in supplements to wages and salaries per employee on nonagricultural payrolls provides an external indicator of fringe benefit cost pressure on per employee basis.

3. Professional Fees: Medical

External Price Variable (used in National Hospital Price Index)—Percentage change in the charges for physicians' services as measured by the Consumer Price Index for All Urban Consumers (component of medical care services).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly

The medical fees category primarily represents fees billed to hospitals by physicians for services furnished in hospital ancillary departments such as radiology, pathology and anesthesiology. These services are usually billed under Medicare Part B, and as such are not part of the prospective payment system inpatient market basket. Salaries for staff physicians as well as for interns and residents are not included in this classification. The physician services component of the Consumer Price Index is used to approximate percent changes in fees charged. It is assumed that the physician specialists working in hospitals exhibit similar cost pressures in maintaining their practice and, thus, would generally modify their charge structure in line with the rest of the profession.

4. Professional Fees: Other

External Price Variable—Percentage change in the employment cost index for professionals and technicians.

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

The cost category "Professional Fees: Other," includes fees for legal, auditing, consulting, and other hospital-specific professional contracting. As such, this cost category reflects salaries as well as expenses for travel, research assistance, clerical assistance, and overhead. The proxy chosen is the Employment Cost Index for Professionals and Technicians.

5. Capital-Related Costs: Depreciation on Fixed Assets

External Price Variable—Percentage change in Engineering News-Record Building Cost Index (10-year quarterly moving average).

Data Source—Engineering News-Record

Frequency—First week of a month.

As a general rule, capital costing is an accounting concept that attempts to relate the value of an asset to its period of consumption ("time-release" basis) by allocating a fixed rate of depreciation on a periodic basis. Operating costs, in contrast, are generally considered to have a concurrent period of expenditure incurrence and asset consumption. By its very nature, accounting for depreciation costs entails judgment as to the useful life of a class of assets and a method for updating its replacement value. The following points highlight the critical areas of concern regarding the treatment of capital costs in the hospital market basket:

- Capital assets represent present and future costs that do not lend themselves to adjustment based on short-term financial conditions, as opposed to operating costs.

[3] American Hospital Association, *National Hospital Panel Survey.*

[4] U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business,* July 1982.

• Although capital investment costs do not change year-to-year, their replacement value does. The hospital industry must arrange the means by which a sufficient flow of capital payments provide for replacement costs.

• Two distinct methods can be recognized by the Medicare program in facilitating a "sinking fund" for capital asset replacement—

—The HCFA market incorporates changes in measured costs for constructing or manufacturing classes of assets. Any future increases in reimbursement to hospitals for its capital cost that were incurred in prior years can be invested and achieve a return contributing to ability to fund potential asset replacement; and

—Especially in the case of fixed assets, the depreciation flow rate to hospitals, based on the useful life of such assets, far exceeds the proportion of the mortgage payments devoted to the principal during the earlier years of the mortgage in cases in which capital is funded by debt. The substantial increment affords hospitals the ability to further enhance their fund for future asset replacement. In addition, the reimbursement practice has been to allow taxable institutions to achieve a return on equity investment far superior to market rates of return on other investment instruments.

In regard to depreciation on fixed capital assets such as buildings or fixed equipment, a judgmental determination is necessary for forecasting purposes on two elements of updating for replacement cost:

• The type of asset measured by the variable; and

• The lag period selected for incorporating price changes.

For purposes of developing this rebased market basket, the building cost index derived and maintained by the Engineering News-Record (ENR) was selected as the best currently available source of measuring changes in costs of fixed assets. The ENR building index is published monthly by the Bureau of Economic Analysis in its *Survey of Current Business* (Current Business Statistics). This index tabulates surveyed cost changes in 20 cities for three major building categories and three classifications of skilled tradesmen predominantly utilized by the construction industry. ENR assigned aggregate weights to fixed quantities of structured steel, Portland cement and lumber. In the labor component, it calculated an average wage paid to carpenters, bricklayers, and structural ironworkers. The actual weightings were based on the relative importance of the various components in construction that were obtained from a survey of construction authorities. Because the ENR index deals only with the effects of trends in wage rates and material prices, it is considered an appropriate means of updating the fixed asset component of the hospital market basket. (A number of other indexes were reviewed and evalauated for use, including some hospital or health-specific measures. This broad-based index met several criteria. We are continuing research in this area.)

The other element in forecasting price movements of fixed capital involves the selection of a 10-year (40-quarter) moving average of the ENR index. The concept of using current price depreciation as an appropriate indicator of depreciation relies on the notion that actual replacement activity mainly occurs across a proportion of facilities in any given year. Therefore, the introduction of a current price index should be effected on a longer term moving average basis. This has the added benefit of providing less volatility with which hospitals can develop and implement the planning processing. From an economic prospective, a longer term average is felt to be more reflective of the inherent stability of escalation in capital costs.

6. Capital-Related Costs: Depreciation on Moveable Assets:

External Price Variable—Percentage change in the cost of machinery and equipment as measured by the Producer Price Index (SIC code #11) (five-year quarterly moving average).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Similar concerns to those for fixed assets play a role in establishing an appropriate means of forecasting price movements in moveable assets. However, in this sector, replacement rates tend to be more frequent for various reasons: obsolescence, maintenance costs, and the shorter time span of the useful life assigned to such assets. A five-year (20 quarter) moving average of changes in the cost of machinery and equipment reflects changes in prices for the period in use of much of these assets before replacement. A broad-based index for machinery and equipment was used in the absence of a relevant fixed-weight index of hospital machinery and equipment. A disadvantage in the use of this proxy lies in the fact that rapid technological rate of improvements in medical care equipment may exhibit different price trends than that for other nonmedical furniture and appliances. The overwhelming rate of innovation in this segment of durable goods precludes the formulation of any index that could portray period-to-period changes in costs for health care equipment.

A broad-based index of machinery and equipment was selected to proxy all movable assets of hospitals because it encompasses a wide range of heavy duty electrical and mechanical products. Included in the array of manufactured products are furnaces and ovens, power tools and accessories, pumps and compressors, scales and balances, elevators, and air-conditioning and refrigeration equipment. Many electrical product components are also evaluated within this variable. Of special note, this proxy incorporates x-ray equipment and other testing and measuring instruments, as well as commercial laundry equipment.

Although it was preferable to disaggregate movable assets into distinct functional groupings so that the distinction in price movements could be recognized, there is no up-to-date, reliable fixed weight index for hospital assets available. When the 1977 Input/Output analysis for health sector capital goods is released, it may be possible to construct such an index.

7. Capital-Related Costs: Interest

External Price Variable—Weighted average of percentage change is yield on domestic municipal bonds, *Daily Bond Buyer* (20 bonds) (seven-year quarterly moving average) (85.34 percent) and percentage change in average yield on Moody's AAA corporate bonds (seven-year quarterly moving average) (14.66 percent).

Data Source—For municipal and corporate bonds, U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business,* Finance Section. BEA publishes the yield on the Thursday nearest the end of the month.

Frequency— For municipal and corporate bonds, weekly.

Long-term debt is contracted over time at interest rates in effect at the time the debt is incurred. The effect of changing long-term interest rates is approximated by a seven-year quarterly weighted moving average of domestic municipal bonds and corporate bonds. To account for any differences that may occur in interest rates for proprietary hospitals, compared to voluntary hospitals, 1982 weights of proprietary interest costs were obtained from unpublished AHA data.

8. Capital-Related Costs: All Other

External Price Variable Percentage change in residential rent as measured by the Consumer Price Index for All Urban Consumers.

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

In addition to depreciation and interest, which predominate the cost of capital, there are several other, relatively minor cost expenditures that may be considered as capital-related. Payments for fire and allied property insurance, leases and rentals, and real estate taxes all fall within this category. A measurement of rental costs would implicitly recognize these related cost factors. Since there exists no commercial rental proxy, residential rental is a reasonable proxy that can, over time, reflect the trend in price movements of the residual capital-related costs.

9. Fuel Oil, Coal, and Other Fuel

External Price Variable—Percentage change in the cost of refined petroleum products as measured by the Producer Price Index (SIC code #057).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Institutions purchase heating fuel in bulk quantities. Accordingly, price movement of this commodity is appropriately measured at the wholesale level. This proxy incorporates various distillates and grades of fuel oil that are primarily utilized in the heating of plants. Since the cost of refining is included in the price charged for this fuel, use of a proxy reflecting only changes in the cost of crude oil was not considered adequate.

10. Electricity

External Price Variable—Percentage change in the cost of electric power as measured by the Producer Price Index (SIC code #054).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

This proxy includes rates charged to commercial users (40 kw-demand), as well as to industrial users (500 kw-demand). Since the hospital industry is composed of both small and large size plants, its costs will incorporate both of these rate classifications and this cost index is, therefore, considered appropriate.

11. Natural Gas

External Price Variable—Percentage change in the cost of gas fuels as measured by the Producer Price Index (SIC code #0531).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

This proxy measures both domestic and imported costs of various gas fuels including liquified petroleum gas. Purchases by hospitals are generally from a regional gas company which may utilize all types of gas fuel; hence, a broadly-defined index of costs of gas fuels is appropriate.

12. Motor Gasoline

External Price Variable—Percentage change in the cost of gasoline as measured by the Producer Price Index (SIC code #0571).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Hospitals maintain a fleet of vehicles, including ambulances, and would generally purchase motor fuel at wholesale quantities. This index is composed of all grades of gasoline (regular, unleaded, and premium) used by different classes of vehicles.

13. Water and Sewerage

External Price Variable—Percentage change in the cost of water and sewerage maintenance, as measured by the Consumer Price Index for All Urban Consumers.

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly

Costs for this combined product and service category are generally for purchases from municipal entities or utility companies. There are no data available on cost to preferred commercial users of these services and, thus, the Consumer Price Index for water and sewerage is used to approximate price changes facing hospitals.

14. Malpractice Insurance

External Price Variable—Percentage change in the hospital malpractice insurance component in the AHA Annual Survey (for the period 1966–1976). Set by DHHS in collaboration with AHA from 1977 to 1981. Percentage changes in hospital insurance premium data from the Insurance Services Offices from 1982 through April 1985 and thereafter extrapolated.

Data Source—Unpublished data provided to DHHS by AHA, Office of Research Affairs, and unpublished data from the Insurance Services Offices.

Frequency—For AHA and DHHS estimates and data, annually, and for the Insurance Services Offices data, quarterly.

The costs associated with professional liability in hospitals are difficult to quantify in both cross-section and time-series data. Hospitals may self-insure, pay on a claims-made basis, or purchase professional liability insurance for a fixed or changing level of coverage. Hospitals located in the same area may have varying experience ratings; therefore, premium rates may differ significantly. No national or regional data source currently exists that can quantify precisely the many variations in the cost associated with professional liability in hospitals.

15. Pharmaceuticals

External Price Variable—Percentage change in drugs and pharmaceuticals as measured by the Producer Price Index (SIC code # 063).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, table 23.

Frequency—Monthly.

Hospitals commonly purchase drugs in bulk quantities and, accordingly, the Producer Price Index is an appropriate measure. This category consists of medicinal and chemical preparation, prescription and over-the-counter drugs, and other biological products administered to patients for either diagnostic or therapeutic benefit.

16. Food: Direct Purchases

External Price Variable—Percentage change in the cost of processed foods and feeds, as measured by the Producer Price Index (SIC code # 02).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Items included under this variable are purchased directly by those hospitals that independently operate their dietary department or certain segments of their dietary service. Purchases tend to be in bulk quantity for both perishable and nonperishable foodstuffs, and prices generally reflect those available at the wholesale price level. Major groups of processed foods measured under this classification include cereal and bakery products, meats, poultry and fish, dairy products, processed fruits and vegeatables, beverages, and other

miscellaneous processed foods. Other ingredients utilized in the course of preparing the culinary output, such as oils, shortening and confectionary sweeteners, are also reflected in this index. Since price movements for raw, unprocessed farm products, such as milk and eggs, tend to parallel the price trends for processed foods, it is appropriate to use this index as a proxy for both categories of food purchases.

17. Food: Indirect Purchases

External Price Variable—Percentage change in the cost of food purchased away from home, as measured by the Consumer Price Index for All Urban Consumers (SIC code # 19).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Much of the hospital industry employs outside contractors to facilitate dietary preparations and service requirements for hospital patients and personnel. As such, it includes the cost of food products, other labor costs and nonlabor costs, such as napkins, flatware and glassware incurred by these contractors. Although a consumer price index is utilized for products typically purchased at a bulk rate, this index is considered relevant in that much of the food inputs provided at food service establishments are generally purchased at the wholesale level, especially by the nationwide chains so prevalent in the restaurant industry today.

18. Chemical and Cleaning Products

External Price Variable—Percentage change in the cost of industrial chemical products, as measured by the Consumer Price Index for All Urban Consumers (SIC code #061).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

The hospital industry consumes a vast variety of chemical products, ranging from organic and norganic solutions and compounds to cleaning agents and hygienic paraphernalia. The variable "Industrial Chemicals" was selected as representatives of all chemical products and derivatives because the more broad-based index of "Chemicals and Allied Products" subsumes to a great extent the surveyed prices for drugs and pharmaceuticals, and for biological products, each of which is categorized and measured elsewhere in this market basket index. Industrial chemicals are comprised of both organic and inorganic solids, liquids, and gases.

19. Surgical and Medical Equipment

External Price Variable—Percentage change in Medical and Surgical instruments, as measured by the Producer Price Index (SIC code #1562).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Products and parts used for surgical and medical purposes incorporate a multitude of minor equipment and accessories too low in price to capitalize. This equipment ranges from parts of diagnostic and therapeutic instruments to pacemakers. Since most of these products utilize electronic components, a proxy reflecting a broad diversification of electronic parts and accessories was selected to monitor price movements for this category of costs. Included in the BLS survey under this classification are x-ray equipment and parts, generator parts, batteries and transistors, and a host of intricate mechanisms that are utilized in manufacturing an electronic appliance. Most of these specialized products are generally not available at the consumer level, and the Producerr Price Index proxy is, therefore, indicated.

20. Photographic Supplies

External Price Variable—Percentage change in the cost of photographic supplies, as measured by the Producer Price Index (SIC code #1542).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

A considerable quantity of photographic materials are consumed by the hospital industry, especially in the diagnostic services. Radiology and pathology departments use a variety of photographic apparatus and films. Therefore, it is reasonable to conclude that items under this classification are usually purchased in wholesale lots and changes in prices are best quantified by the Producer Price Index proxy.

21. Rubber and Plastics

External Price Variable—Percentage change in the cost of rubber and plastic products, as measured by the Producer Price Index (SIC code #07).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

The rubber and plastic product category includes a wide array of miscellaneous rubber and plastic products, including rubber gloves, rubber hoses, and disposable plastic products. Among the items measured by this index are rubber clothing and coated fabrics, plastic packaging, and plastic tableware. Purchases are at the wholesale level, and the broad-based Producer Price Index for rubber and plastic products was chosen because it has tended to approximate combined price movements of both components historically.

22. Paper Products

External Price Variable—Percentage change in the cost of converted paper and paperboard products, as measured by the Producer Price Index (SIC code #0915).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Products measured under this category include printing and office paper goods, disposable garments and tableware, and packaging products. Hospitals are consumers in each of these areas. The proxy chosen encompasses an array of converted paper and paperboard products and various milled paper products, such as tissues and napkins, bags and writing paper.

23. Apparel

External Price Variable—Percentage change in the cost of apparel, as measured by the Producer Price Index (SIC code #381).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Hospitals are major purchasers of various types of textile goods, including uniforms, gowns, sheets, blankets, pillow cases, towels, and washcloths. This proxy contains an array of men's and women's garments. Since these products tend to be acquired in multiple quantities, the Producer Price Index for apparel is an appropriate variable.

24. Minor Machinery and Equipment

External Price Variable—Percentage change in the cost of machinery and equipment, as measured by the Producer Price Index (SIC code #11).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

This category is designed to measure the various types of tools, accessories and parts that are minor in cost and, therefore, not capitalized. A broad-based Producer Price Index for minor machinery and equipment is used to

approximate price movements for this cost category.

25. Miscellaneous Products

External Price Variable—Percentage change in the cost of all finished goods, as measured by the Producer Price Index.

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly

This residual category is intended to measure a diversified grouping of consumable commodities utilized by the hospital, each of which is considered too small to individually have a measurable impact on price movements within this market basket. Some of these groups are identified as metals and metal products, nonmetallic mineral products, minor transportation equipment and parts, minor furniture and other household durables, photographic equipment, and other consumable products. Since these products are at the finished stage, a Producer Price Index measuring all finished goods is appropriate for such a broad-based grouping.

26. Business Services

External Price Variable—Percentage change in the average hourly earnings of employees engaged in the business services industry, as measured by the Employment and Earnings Index (SIC code #73).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings.*

Frequency—Monthly.

As is true in the majority of the service industry, the price charged for the various services furnished primarily reflects the salaries and wages paid the employees of each particular firm. Other costs do indeed play a role in setting prices, but the key ingredient, labor-related costs, are predominant. This is also true for the hospital service industry. Therefore, a measurement of changes in average labor costs for a particular service-based industry is an appropriate indicator of the changes in prices charged to clients of those services.

By far, the largest component of services provided to a hospital from external sources, representing over a third of the total, is business services. A broad spectrum of business services purchased by hospitals includes computer programming and data processing, management and consulting services, stenographic services, credit collection, marketing, and numerous other administrative functions. Among the industries surveyed by the Bureau of Labor Statistics and classified under Business Services are those enumerated above, as well as a number of miscellaneous business services such as public relations or protective services. Since computer and data processing services compose a sizable segment on their own, those services were measured and proxied separately from other business services.

27. Computer and Data Processing Services

External Price Variable—Percentage change is the average hourly earnings of employees engaged in firms furnishing computer and data processing services, as measured by the Employment and Earnings Index (SIC Code #737).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings.*

Frequency—Monthly.

This rapidly growing sector accounts for over 15 percent of all outside services purchased by hospitals. Although many hospitals rely on their internal staff for the day-to-day operations of their information processing needs, those institutions also often obtain the consulting services of firms specializing in the design and implementation of a computerized data-gathering-and-monitoring system. In addition, outside firms are often "on call" in facilitating solutions to any technical problems that may arise or to adopt a particular system to additional or modified uses. Changes in average hourly earnings in the computer and data processing services are an appropriate measure of price movements in this highly labor-intensive industry.

28. Transportation and Shipping

External Price Variable—Percentage change in the transportation component of the Consumer Price Index for All Urban Consumers.

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

This cost category encompasses a diverse group of transportation services utilized by the hospital industry. It includes public transportation services that may be used for business travel and private transportation sources such as ambulance travel for hospital patients. The cost of shipping and motor freight fees are applied to many hospital purchases. Each of these types of transportation costs is embodied in the total transportation component of the Consumer Price Index, which measures both private and public transportation modes. Since shipping fees are basically a function of the cost of maintaining the vehicles used to haul freight, this index is considered appropriate in that it also measures the underlying cost of operating a vehicle such as repairs, insurance fees, motor fuels, finance charges, and other incidentals.

29. Telephone

External Price Variable—Percentage change in the cost of telephone services, as measured by the Consumer Price Index for All Urban Consumers.

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

This component includes charges for both local and long-distance phone calls. In this rapidly changing industry, the cost to the phone companies of furnishing worldwide facilities fundamentally stems from a vast capital infrastructure and the most sophisticated, up-to-date equipment. Since labor-related costs are also accounted for in fixing telephone fees, the Consumer Price Index for telephones is used as the proxy.

30. Blood Services

External Price Variable—Percentage change in the cost of providing blood and related biologicals, as measured by the Producer Price Index (SIC code #063711).

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

Blood supplies are often provided to hospitals from external sources, predominantly from public service agencies. In addition to whole blood products, many derivatives are obtained for specific types of operations. These include plasma, platelets, and other blood components. The index in the Producer Price Index measures both human blood and its derivatives, as well as other biological products, and, as such, is an appropriate measure of price movements.

31. Postage

External Price Variable—Percentage change in the cost of postage, as measured by the Consumer Price Index for All Urban Consumers.

Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*

Frequency—Monthly.

In recent times, many businesses, including the hospital industry, have begun to make use of alternative mail services for either parcel post or express mail. However, the prevalent cost of postage services still appears to be linked to mail transported by the U.S. Postal Service. As such, the index for postage surveyed by the Consumer Price Index is considered an appropriate measure of price movements for this service.

32. All Other Services: Labor-Intensive

External Price Variable—Percentage change in the average employment cost index for all service workers.
Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings.*
Frequency—Monthly.

The majority of the residual services not measured before are highly labor-intensive and are grouped together for purposes of using the employment cost index for workers engaged in the services sector as a forecast proxy. Some of these individual services purchased by hospitals include miscellaneous repairs, commercial laundry, refuse systems, and general building services.

33. All Other Services: Nonlabor-Intensive

External Price Variable—Percentage change in the all-items component of the Consumer Price Index for All Urban Consumers.
Data Source—U.S. Department of Labor, Bureau of Labor Statistics, *Monthly Labor Review.*
Frequency—Monthly.

The remaining residual services were classified as nonlabor-intensive and included such services as insurance (not capital-related), bank service charges, fees for business and professional associations, and vehicle rentals. In this case, an overall measure for all services covered by the Consumer Price Index is an appropriate indicator.

Appendix B—Regulatory Impact Analysis

A. Introduction

Executive Order 12291 (E.O. 12291) requires us to prepare and publish an initial regulatory impact analysis for any proposed regulations that would be likely to result in: (1) an annual effect on the economy of $100 milion or more, (2) a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions, or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. Several provisions proposed in this document would exceed the $100 million threshold under E.O. 12291. Therefore, we are including an impact analysis that contains a discussion of each significant proposed change.

In addition, for proposed regulations we prepare and publish an initial regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that the regulations would not have a significant economic impact on a substantial number of small entities. Under the RFA, we treat all hospitals as small entities. It is clear that these proposed changes would affect a substantial number of hospitals and the effects on some would be significant. Therefore, we are providing an initial regulatory flexibility analysis.

We are also including in this document a regulatory impact and flexibility analysis of the interim final rule published May 6, 1986 (51 FR 16772) to implement provisions of Pub. L. 99-272 related to operation of the prospective payment system during FY 1986. Due to time constraints, the Director of the Office of Management and Budget waived the requirements of E.O. 12291 for that interim final rule, and the Secretary deferred the preparation of a regulatory flexibility analysis, which is consistent with section 608 of the RFA. We promised in that document to prepare and publish the necessary analyses in conjunction with this proposed rule.

The discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis meeting the requirements of E.O. 12291 and the RFA.

B. Objectives

We expect these proposed changes to further our original objectives in implementing the prospective payment system. The prospective payment rates create incentives similar to the incentives a hospital would face in pricing and marketing its services in a conventional market. By paying all hospitals the same market-like rate for like services, we let hospitals know in advance the amount they will be paid per discharge. We give them both an opportunity to receive this payment regardless of their specific cost experience, and a strong incentive to operate more efficiently, minimizing unnecessary costs. Unlike a cost limitation approach, which achieves savings largely by disallowing Medicare payment for costs in excess of a specific limit, the prospective payment system achieves savings by intensifying hospitals' incentives to operate efficiently. Thus, our objectves include—

- Restructuring hospitals' economic incentives;
- Basing payment on a system that identifies the product being purchased more accurately than cost reimbursement;
- Reinforcing the role of the Federal government as a prudent buyer of services; and
- Restraining the rate of hospital cost increases, thus moderating the outflow of expenditures from the Medicare trust fund, while maintaining high quality care.

In addition, we share national goals of deficit reduction and restraints on government spending in general. We believe these proposals will further all of our goals while maintaining the financial viability of the hospital industry and assuring access to high quality care for beneficiaries.

We expect these proposed changes to further those objectives while avoiding or minimizing unintended adverse consequences and ensuring that the outcomes of this payment system are, in general, reasonable and equitable. Thus, the intent is to refine further the prospective payment system without undercutting our objectves.

C. Problems of Impact Quantification and Attributing Causality

In preparing previously published interim, proposed, and final rules concerned with the prospective payment system, we have used the best data available to analyze the rules and their implementing procedures. Moreover, since the beginning of the prospective payment system, we have developed increasingly sophisticated models of how the prospective payment system works. Nonetheless, at present, we still have no adequate way to model potential behavioral changes on the part of hospitals, hospital managers and employees, physicians, suppliers, or beneficiaries. Further, changes in the private sector, such as changes in the ways that employers finance and control health benefits, interact with the behavioral incentives created by the Medicare payment system. We do not have the capability to model such interactions.

We continue to study many aspects of the prospective payment system with the intent of obtaining more adequate data for the purpose of better

quantifying the effects of behavioral changes caused by the payment system. Examples of these initiatives include various reports to Congress, as required by section 603 of Pub. L. 98–21 and sections 9113 and 9114 of Pub. L. 99–272. These studies will examine many issues, including the feasibility and impact of eliminating or phasing out separate urban and rural DRG prospective payment rates, the feasibility and desirability of applying the payment methodology to payment by all payors for inpatient hospital services, and the impact of outlier and transfer policies on rural hospitals. We are also required, under section 603(a)(2)(A) of Pub. L. 98–21, to study and report annually to the Congress on the impact of the prospective payment system. In addition to these initiatives, we and others (such as the hospital industry) have undertaken a variety of studies on the effects of the prospective payment system, such as examining selected aspects of hospital management behavior under the prospective payment system, to be able to predict better certain effects and outcomes from the system.

Nonetheless, we are limited in our ability to attribute the causation of particular changes in the hospital industry directly to particular regulations. This is made particularly difficult by the changing nature of the health care sector, and the nature of the prospective payment system itself. The prospective payment system is but one of numerous efforts aimed at controlling rapidly rising health care costs. In many cases, then, it may be difficult to determine the extent to which the prospective payment system, or some other initiative, caused the result, or whether two (or more) initiatives caused the result interactively. Further, the prospective payment system itself is interactive and it is sometimes difficult to isolate the effects, within the system, of a particular change of policy or procedure.

Apart from the more easily identifiable initiatives that are affecting the health care market, especially on the demand side, changes also have been occurring on the supply side. Most notable of these changes is the increase in the supply of physicians, which enhances the competition for patients among providers. There also has been significant growth of facilities furnishing out-of-hospital treatment and of health maintenance organizations (HMOs). In addition, home health services are the fastest growing component of the Medicare program.

In view of the problems we have experienced in quantifying impacts and attributing causality, we believe that the approach we are taking in the specific impact discussions below is the most feasible one. In some cases we have included quantitative estimates of program savings or anticipated changes in payment levels. However, since it is not possible to develop a reliable quantitative analysis and comparison of the costs and benefits of all the provisions to the various affected parties, we have primarily focused on explaining the kinds of interactions and the decisions that those parties will have to consider. As with previous impact analyses, we are soliciting comments and information about the anticipated effects of these proposed changes to the prospective payment system.

D. Basis and Methodology of Estimates

Much of the available Medicare program data still reflect patterns and trends of utilization and payment under cost reimbursement. Where it is feasible and appropriate, we have used these data to model and analyze the effects of particular proposals. However, the quantitative estimats given below should be received with a qualified recognition of the limitations of the data on which they are based. Moreover, from October 1, 1985, through April 30, 1986, the prospective payment system was operating under legislative constraints that we had not expected; further, the inclusion of capital-related costs and implementation of changes required under Pub. L. 99–272 have made the task of modeling more complex. Our analysis is also made more difficult by the necessity to consider and present separately the impacts associated with the interim final rule published May 6, 1986.

Interactive effects, the recent legislative freeze, and the phasing in of different facilities (and sometimes areas) on different schedules compel us to be tentative. In particular, we must point out that as yet we have only incomplete data on the effect on hospital-specific costs per case of the change in the cost report allocation sequence for teaching hospitals in New York State. Thus, any estimates below, especially those reflecting regional rates for the Mid-Atlantic region, must be viewed as approximate.

Because this analysis includes a discussion of the May 6, 1986 final rule as well as provisions of this proposed rule, and because the provisions of Pub. L. 99–272 created certain analytic problems through extension of the transition period (with the Oregon exception) and requirements to restandardize the FY 1987 rates, we have had to consider carefully what baseline we would use to assess the relative impacts of the various provisions of this proposed rule. In previous impact analyses, we have simply used projected payments for the fiscal year preceding the year for which we were setting rates as the baseline, and represented the impact of specific provisions relative to the projected percent change in total payments.

As a result of the enactment of Pub. L. 99–272, however, for FY 1986 payments have been made on two distinct bases. Thus, we had a choice: we could use FY 1985 rates (that is, the rates actually paid during the first seven months of FY 1986), or the FY 1986 payment rates (that is, those paid during the period May 1, 1986 through September 30, 1986) as a baseline.

We decided to use the payment parameters in effect for the seven-month period from October 1, 1985 to April 30, 1986 as our initial baseline. Because of statutory postponements in implementing the September 3, 1985 rule, the rates paid during the first seven months of FY 1986 reflect the FY 1985 payment rates. Thus, the following discussion of the provisions of the interim final rule published May 6, 1986 compares payments for the baseline period to the May to September FY 1986 payments. The FY 1986 payments in effect from May through September 1986 are then used as the baseline for FY 1987 impact assessments of the provisions of this proposed rule. To ensure comparability, we assumed that all payment periods and payment parameters used in the comparisions were in effect for a full twelve months.

Generally, to assess the effect of a specific provision, we have treated all hospitals in our database as if they had the same cost reporting period; that is, a cost reporting period coinciding with the Federal fiscal year. In some instances, however, we want to reflect the effects of hospitals' phasing in on different schedules. Those instances, such as the estimates of payment per case, are clearly identified below. Our model does not take into account any prospective behavioral changes in response to these proposals.

E. Hospitals Included In and Excluded From the Prospective Payment System

Since October 1983, hospitals operating under prospective payment have been phasing into the system according to their own accounting year starting dates. Further, since September 1985, both Massachusetts and New York

have discontinued their waivers, and hospitals in those States have entered the prospective payment system. As of January 1, 1986, about 5700 hospitals (84 percent of all Medicare-participating hospitals) were operating under the prospective payment system. Only 169 hospitals remain excluded from the prospective payment system because of waivers (New Jersey and Maryland) or demonstrations (Rochester and Finger Lakes regions of New York State).

As of January 1, 1986, 738 Medicare hospitals were excluded from the prospective payment system and continue to be paid on the basis of reasonable cost reimbursement, subject to hospital-specific limits on the rate of their cost increases. Examples of these hospitals include psychiatric, rehabilitation, alcohol/drug, long-term, and children's hospitals. Another 1,598 psychiatric, rehabilitation and alcohol/drug units, in hospitals included in the prospective payment system, are excluded from prospective payment as of the same date. These units, too, are paid on the basis of reasonable cost reimbursement, subject to hospital-specific limits on the rate of their cost increases.

More than four hundred hospitals are being paid on various special bases under the prospective payment system, as required by statute. They include hospitals accorded special treatment as described in our regulations at 42 CFR Part 412, Subpart G, such as sole community hospitals, and cancer treatment and research hospitals. Also included in this group receiving payment on special bases are referral centers and hospitals that previously allowed extensive direct billing under Part B of Medicare.

F. Implementation of Certain Provisions of COBRA

1. General Discussion

On May 6, 1986, we published an interim final rule with comment period (51 FR 16772) implementing certain provisions of Pub. L. 99-272 that affected operation of the prospective payment system during FY 1986, as well as subsequent years. Although these statutory provisions generally afforded us little administrative discretion, we promised to prepare an analysis of the impact of implementation of those provisions and publish it in conjunction with this proposed rule.

2. Statutory Increase in Payment Rates

The final rule we published on September 3, 1985 would not have increased payment rates under the prospective payment system for FY 1986. However, as a result of Pub. L. 99-272—

- For prospective payment hospitals, the update to the adjusted standardized rates of one-half of one percent is effective for discharges occurring on or after May 1, 1986. The hospital-specific rates are increased by zero percent for discharges occurring during the first seven months of a hospital's cost reporting period beginning in FY 1986 and by one-half of one percent for discharges occurring during the remaining five months of that cost reporting period.
- For hospitals excluded from the prospective payment system, the hospital's target amount for cost reporting periods beginning in FY 1986 is the previous year's target amount increased by five-twenty-fourths of one percent (that is, an increase of one-half of one percent for five months of the 12-month cost reporting period).
- For purposes of determining update percentages for discharges occurring on or after October 1, 1986 or cost reporting periods beginning on or after October 1, 1986, as appropriate, the applicable percentage increase for both prospective payment hospitals and excluded hospitals, for discharges occurring in FY 1986 or cost reporting periods beginning in FY 1986, as appropriate, is deemed to have been one-half of one percent throughout the applicable period.

We estimate that these increases will result in increased payments to hospitals of $35 million in FY 1986 and $210 million in FY 1987. Excluded hospitals and units account for a small proportion of total inpatient hospital expenditures, and would receive, in the aggregate, less than $2 million more in cost reporting periods beginning in FY 1986.

Hospitals under the prospective payment system will benefit by a direct increase in payment rates. Because the increase is a simple percentage increase, hospitals that already received high payment amounts, on the average, based on their wage indexes and case mix, would receive higher dollar increases than hospitals that receive lower average payments.

Excluded hospitals and units will benefit from increased target amounts in different ways, depending on the change in the relationship of their average costs per case to their new target amounts. Hospitals that would have had costs per case under their target amounts before the increase will benefit from larger incentive payments (that is, payments in excess of cost under § 405.463(d)(2)). Hospitals that have costs greater than their target amounts even with the increase nonetheless will benefit from increased reimbursement. A few hospitals that might otherwise have experienced target amount payments slightly less than their cost per case may actually receive small incentive payments, instead. However, because the increase in the target amount is relatively small, such cases would be rare.

3. No Retroactive Application of the HCFA Adjusted Gross Wage Index

For purposes of determining the prospective payments to hospitals in FY 1984 and FY 1985, we used calendar year 1981 hospital wage and employment data obtained from the Bureau of Labor Statistics' (BLS's) ES 202 Employment, Wages and Contributions file for hospital workers to construct the wage index. However, the September 3, 1985 final rule set forth a revised hospital wage index that is based on an HCFA survey of hospital gross hourly wage and salary data. This wage index was developed in an attempt to overcome the limitation of the BLS data with regard to full-time and part-time employment.

This revised wage index was not implemented because of the provisions of the Emergency Extension Act of 1985 (Pub. L. 99-107) and the succeeding amendments to that Act. Section 9103(a) of Pub. L. 99-272 specifies that, for discharges occurring on or after May 1, 1986, prospective payments to hospitals are to be adjusted to reflect the changes made in the September 3, 1985 final rule relating to the hospital wage index. The retroactive application of the revised wage index to cost reporting periods beginning on or after October 1, 1983 is repealed.

In May the 6, 1986 rule, we made adjustments to the wage index published in the September 3, 1985 final rule to correct data errors. On the whole, the effect of these corrections was slight, especially in comparison with the effect of the repeal of retroactive application of the revised wage index.

As shown in the impact analysis of the September 3, 1985 final rule (50 FR 35757), the aggregate effect of retroactive application of the revised wage index would have been a 0.11 percent reduction in FY 1986 payments. However, as a result of the repeal of the retroactivity provision, there will be no such reduction.

4. Extension of the Transition Period

Section 9102 of Pub. L. 99-272 extended the prospective payment

system transition period by making the following changes;

• *Hospital-specific/Federal blend.* For cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the blend of hospital-specific and Federal portions is 50 percent hospital-specific and 50 percent Federal for the first seven months of the cost reporting period and 45 percent hospital-specific and 55 percent Federal for the remaining five months of the cost reporting period. For cost reporting periods beginning in FY 1987, the blend is 25 percent hospital-specific and 75 percent Federal. Starting with cost reporting periods beginning in FY 1988, the payment rate is based exclusively on the Federal portion.

• *Regional/National Blend of Federal Rate.* For discharges occurring in FY 1986, the Federal portion is made up of 25 percent national and 75 percent regional. For discharges occurring in FY 1987, the combined rate is 50 percent national and 50 percent regional. The Federal portion is based exclusively on the national rate beginning in FY 1988.

Further, under the provisions set forth in section 9102(d)(4) of Pub. L. 99–272, all hospitals subject to the prospective payment system that are located in the State of Oregon are excepted from the changes made to the transition period by the preceding paragraphs of section 9102 of Pub. L. 99–272. Section 9102(d)(4) of Pub. L. 99–272 further specifies that for those hospitals located in Oregon, the following applies:

• *Hospital-specific/Federal blend for Oregon.* Section 9102(d)(4)(B) states that for the first seven months of a cost reporting period beginning in FY 1986, the payment rate consists of a blend of 50 percent of the hospital-specific rate and 50 percent of the Federal rate. For the remaining five months of a cost reporting period beginning in FY 1986, the blend is 25 percent of the hospital-specific rate and 75 percent of the Federal rate. For cost reporting periods beginning on or after October 1, 1986, the payment rate is comprised solely of the Federal rate.

• *Regional/National blend of Federal rate for Oregon.* For discharges occurring on or after October 1, 1985 and before May 1, 1986, the Federal rate consists of 75 percent of the regional rate and 25 percent of the national rate. For discharges occurring on or after May 1, 1986 and before October 1, 1986, the Federal rate consists of 50 percent of the regional rate and 50 percent of the national rate. For discharges occurring on or after October 1, 1986, the Federal rate is comprised solely of the national rate.

Thus, despite the delay of implementation of the September 3, 1985 final rule, Oregon hospitals will make the transition to a fully national Federal rate at the same time all hospitals would have, had the transition not been extended.

As discussed above in section D. of this analysis, to assess the impact of the revised transition provisions, we had to determine what to use as a baseline. We decided to use the seven-month period from October 1, 1985 to April 30, 1986, annualized to ensure comparability, as the main baseline. Thus, we have compared payment levels for the May 1, 1986 to September 30, 1986 period to that baseline. (See section L. of this impact analysis for the comparable discussion of FY 1987 payment rates.)

The Pub. L. 99–272 changes in blending of hospital-specific and Federal rates, and of national and regional portions of the Federal rates (including the special provisions for Oregon), affect payments to different categories of hospitals differently. The following table illustrates the magnitude of the effect on selected categories of hospitals.

TABLE I.—IMPACT OF PUB. L. 99–272 TRANSITION CHANGES ON PAYMENTS FOR THE PERIOD MAY 1, 1986 TO SEPTEMBER 30, 1986

Category of hospitals	Annualized percent changes in total payments
All Hospitals	0.17
Urban Hospitals	0.19
0–99 beds	0.74
100–404 beds	0.13
405–684 beds	0.23
685+ beds	0.14
Rural Hospital	0.06
0–99 beds	0.07
100–169 beds	−0.12
170+ beds	0.20
By Census Region:	
New England	0.26
Mid Atlantic	0.38
South Atlantic	0.18
East North Central	0.17
East South Central	0.08
West North Central	−0.10
West South Central	−0.07
Mountain	0.11
Pacific	0.32
—Oregon	3.24

5. Additional Payments to Hospitals Serving a Disproportionate Share of Low-Income Patients

Section 9105 of Pub. L. 99–272 added a new section 1886(d)(5)(F) to the Act requiring additional payment for hospitals that serve a disproportionate share of low-income patients. For discharges occurring on or after May 1, 1986 and before October 1, 1988, an additional payment must be made for each prospective payment hospital that meets one of the following criteria:

• During the hospital's cost reporting period, the hospital has a disproportionate patient percentage that is at least equal to—

—15 percent if the hospital is located in an urban area and has 100 or more beds;

—40 percent, if the hospital is located in an urban area and has fewer than 100 beds; or

—45 percent, if the hospital is located in a rural area.

• The hospital is located in an urban area, has 100 or more bed, and can demonstrate that, during its cost reporting period, more than 30 percent of its total inpatient care revenues is derived from State and local government payments for indigent care furnished to patients not covered by Medicare or Medicaid.

For purposes of meeting the latter criterion, it is incumbent upon a hospital to demonstrate that more than 30 percent of its total inpatient care revenues are from State and local government sources and that these revenues are specifically earmarked for the care of indigents (that is, none of that money may be used for any purpose other than indigent care). The following are among the types of care that are not to be included by the hospital as indigent care:

• Free care furnished to satisfy the hospital's Hill-Burton obligation.

• Free care or care furnished at reduced rates made available by the hospital to its employees or by a government hospital to any category of public employees.

• Funds furnished to the hospital to cover general operating deficits.

The disproportionate patient percentage used in the first criterion described above is the sum, expressed as a percentage, of the following two fractions.

1. Patient days of those patients entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding those patients receiving State supplementation only)

Patient days of those patients entitled to Medicare Part A

2. Patient days of those patients entitled to Medicaid but not to Medicare Part A

Total number of patient days

The method of computing a hospital's disproportionate patient percentage and the process for making payments to hospitals that serve a disproportionate share of low-income patients are discussed in detail in the May 6, 1986 rule (51 FR 16777).

The additional payment adjustment for hospitals that meet the

disproportionate patient percentage criterion is determined as follows:

- For urban hospitals with 100 or more beds, the hospital's total DRG revenue (as defined below) is increased by 2.5 percent plus one-half the difference between the hospital's percentage of low-income patients and 15 percent, up to a maximum of 15 percent; that is, the disproportionate share adjustment factor is the lesser of 15 percent or $(P-.15)(.5)+.025$, where P equals the hospital's disproportionate patient percentage expressed as a decimal.
- For urban hospitals with fewer than 100 beds, the hospital's total DRG revenue is increased by five percent.
- For rural hospitals, the hospital's total DRG revenue is increased by four percent.

For a hospital that meets the definition of a disproportionate share hospital based on the indigent care revenue criterion, the payment adjustment is determined by increasing the hospital's total DRG revenue by 15 percent. A hospital's total DRG revenue is the revenue based on DRG-adjusted prospective payment rates (for transition period payments, the Federal portion of the hospital's payment rates) including outlier payments but excluding any other additional payments such as the indirect medical education payment.

Between 900 and 1200 hospitals may qualify for these payments. The large majority, probably at least 700, are expected to be urban hospitals with more than 100 beds. Nonetheless, we expect between 170 and 200 rural hospitals to receive some additional payment under this provision.

We estimate that this will result in additional payments of $200 million to qualifying hospitals for the period May 1, 1986 to September 30, 1986. For FYs 1987 and 1988, we estimate that additional payments to qualifying hospitals will be $600 million and $825 million, respectively. This will not result in an overall increase in Medicare program expenditures for the latter two fiscal years, since the Federal rates for all hospitals will be adjusted to remove the effects of the estimated additional payments, as discussed in section II.A.1.e. of the Addendum to this proposed rule. See section L. of this impact analysis for the effects of that adjustment on the FY 1987 payment rates.

6. Paymnt for the Indirect Costs of Medical Education

Because the indirect costs of medical education are defined in terms of increased operating costs, they are not separately identifiable on the cost report or in other financial or accounting records. Rather, these incremental costs have been statistically estimated as a function of teaching intensity, and a proxy measure (the hospital's ratio of the number of interns and residents to the number of beds) has been used to measure teaching intensity. The coefficient describing this statistical relationship has been expressed as a percentage and applied as the indirect medical education adjustment factor.

Section 9104(a) of Pub. L. 99-272 reduced the education adjustment factor used to determine the indirect medical education payment from 11.59 percent to approximately 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1988. For discharges occurring on or after October 1, 1988, the adjustment factor is equal to approximately 8.7 percent. In addition to being reduced, the adjustment factor is no longer applied on a linear basis, but rather on a curvilinear or variable basis. An adjustment made on a curvilinear basis reflects a nonlinear cost relationship; that is each absolute increment in a hospital's ratio of interns and residents to beds does not result in an equal proportional increase in costs. Therefore, the adjustment factors are only approximately 8.1 percent and 8.7 percent.

For discharges occurring on or after May 1, 1986 and before October 1, 1988, the indirect medical education factor equals the following:

$$2\times\left[\left(\frac{1+\text{interns and residents}}{\text{beds}}\right)^{.405}-1\right]$$

For discharges occurring on or after October 1, 1988, that factor equals the following:

$$1.5\times\left[\left(\frac{1+\text{interns and residents}}{\text{beds}}\right)^{.5795}-1\right]$$

We estimate that implementation of section 9104(a) of Pub. L. 99-272 will result in savings as follows:

Fiscal years	Savings (in millions)
1986	-$175
1987	-630
1988	-910
1989	-1,135
1990	-1,245
1991	-1,355

The savings for FY 1986 are for the period May 1, 1986 to September 30, 1986.

We analyzed the effect that the approximately 30 percent reduction in the education adjustment factor would have on both indirect medical education payments and total payments for teaching hospitals by comparing their annualized payment levels, for the period October 1, 1985 through April 30, 1986 to the new levels, also expressed on an annual basis. Because of the adoption of the required curvilinear method of computation, for most groups of hospitals the effective reduction of the amount of teaching payments was greater than the percent reduction in the teaching adjustment factor, as illustrated by Table II.

TABLE II.—ESTIMATED PERCENT REDUCTION IN TEACHING PAYMENTS [1] FOR THE PERIOD MAY 1, 1986, TO SEPTEMBER 30, 1986

Catergory of hospitals	Annualized percent change in teaching payments [2]
All Hospitals	-35.3
Urban Hospitals	-35.3
0-99 beds	-33.5
100-404 beds	-35.0
405-684	-35.0
685 + beds	-36.0
Rural Hospital	-34.6
0-99 beds	-32.2
100-169 beds	-31.9
170 + beds	-34.8
By Census Region:	
New England	-35.3
Mid Atlantic	-35.4
South Atlantic	-36.2
East North Central	-34.5
East South Central	-33.4
West North Central	-34.9
West South Central	-34.5
Mountain	-35.7
Pacific	-36.5
Teaching Status:	
Non-Teaching	0.0
Resident/Bed Ratio Less than 0.25	-32.7
Resident/Bed Ratio Greater than 0.25	-37.7
Disproportionate Share Hospitals (DHS):	
No Additional Payments	-34.6
Urban DSH less than 100 beds	-36.6
Urban DSH 100 beds or more	-34.7
Rural DSH	-30.7

[1] "Teaching payments" refers to payments under the adjustment for the indirect cost of medical education. See 42 CFR 412.118.

[2] This reflects the estimated proportional difference in total dollar payments for all teaching hospitals in each category; because teaching payments are made only in relation to the Federal portion of the prospective payment rate, and because the Federal portion increased from 50 percent to 55 percent between these two periods, the actual dollar decrease for all hospitals in the aggregate will be less than suggested by these percent changes.

As would be expected, the greatest proportional reduction in payments for the indirect costs of medical education would be experienced by teaching hospitals with high resident-to-bed ratios. Hospitals with resident-to-bed ratios of less than 0.25 are expected to experience, on the average, the equivalent of a 1.48 percent annual reduction in total payments. Hospitals with heavier teaching involvement (that is, hospitals with resident-to-bed ratios equal to or greater than 0.25) will experience, on the average, the equivalent of a 6.47 percent annual

decrease in total payments for the same period.

7. Payment for Indirect Medical Education Costs of Certain Clinics.

Section 602(k) of Pub. L. 98–21, the public law that established the prospective payment system, authorizes waiver of the statutory requirement that nonphysician services be furnished either directly or under arrangement in the case of a hospital that had followed a practice of direct billing under Medicare Part B so extensively that immediate compliance with these requirements would threaten the stability of patient care.

Section 602(k) of Pub. L. 98–21 also requires that we reduce the Medicare Part A payment to hospitals that have such waivers for the amount of Part B billings for nonphysician services furnished to the hospital's inpatients. Therefore, payments for inpatient services are reduced to take into account 100 percent of the reasonable charges (before application of the Medicare Part B deductible and coinsurance amounts) for nonphysician services furnished by an outside supplier.

Generally, a hospital's indirect medical education payment is determined on the basis of the total DRG revenue based on the Federal rates received by the hospital. The DRG revenue received by hospitals that qualify for a waiver does not include the Part B reasonable charges for nonphysician services furnished by an outside supplier. Therefore, our policy for determining the amount of the indirect medical education payment for a hospital that has a waiver has been to base the payment on the DRG revenue based on Federal rates after it has been reduced for Part B billing.

Section 9112(a) of Pub. L. 99–272 amended section 602(k) of Pub. L. 98–21 by adding a provision that specifies that the indirect medical education payment for hospitals that have a waiver is to be computed as if the hospital were receiving under Part A all the payments that were made under Part B because of the waiver. That is, a hospital with a waiver under section 602(k) of Pub. L. 98–21 is treated as if the waiver is not in effect for purposes of computing the additional payment for the indirect costs of medical education. Section 9112(b) of Pub. L. 99–272 specifies that this amendment is effective for cost reporting periods beginning on or after January 1, 1986.

In addition, section 9112(a) of Pub. L. 99–272 amended section 602(k) of Pub. L. 98–21 to specify that, effective April 17, 1986, Part A services billed under Part B under a waiver will be paid at 100 percent of the reasonable charge (or other applicable basis of payment), and that in order to retain its waiver, the hospital must ensure that the supplier that bills for the services accepts this payment as payment in full (that is, the beneficiary is not responsible for payment of the coinsurance, or for any amount in excess of the reasonable charge (or other applicable basis for payment)). In section 9112 of Pub. L. 99–272, Congress specifically stated that payment for Part A services billed under Part B is equal to 100 percent of the reasonable charge and that the entity furnishing the services must accept *this amount* as the full charge. For administrative simplicity, we will not apply the deductible to these payments.

Only 4 hospitals currently have waivers under 602(k). Further, the Secretary's authority under section 602(k) to waive those requirements specified in the Act does not extend to cost reporting periods beginning on or after October 1, 1986. As a result, in terms of overall Medicare expenditures, costs or savings resulting from these time-limited changes are negligible. Nonetheless, hospitals with a 602(k) waiver will experience a significant benefit from increased payments for the indirect cost of medical education. On the other hand, the outside suppliers furnishing services through some waiver hospitals will have to forego billing beneficiaries for charges in excess of Medicare reasonable charges. We expect that this time-limited requirement will not be so costly that affected hospitals will relinquish their waivers.

8. Cumulative and Interactive Effects

Because each of the several changes discussed above may affect a given hospital in different ways, we have analyzed the separate and combined effects of certain of them on selected categories of hospitals. The comparisons we made are based on the percent change in estimated annualized total payments for the periods October 1, 1985 to April 30, 1986, and May 1, 1986 to September 30, 1986. Table III, below, shows the comparative effect of implementation of certain provisions of Pub. L. 99–272, assuming that all hospitals phased into the system on the same schedule, on a Federal fiscal year basis. Note that the column titled "Total Combined Effects" reflects the use of the HCFA survey-based wage index and the 0.50 percent increase to standardized amounts and hospital-specific rates, as well as all the factors included in the separately identified columns.

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TABLE III-ESTIMATED IMPACT OF PUB. L. 99-272 REVISIONS TO OPERATING COST PAYMENTS (EXCLUDING CAPITAL) FOR THE PERIOD MAY 1, 1986 TO SEPTEMBER 30, 1986, COMPARED TO OCTOBER 1, 1985 TO APRIL 30, 1986 PAYMENTS BASED ON FY 1985 PAYMENT PARAMETERS

	Reduction in Teaching Adjustment Factor	Additional Payments to Disproportionate Share Hospitals	Change in Blend (55/45)	Revised Outlier Criteria[1/]	Total Combined Effects[2/]
All Hospitals	-1.21	0.61	0.17	0.95	0.90
By Census Regions					
New England	-1.96	0.22	0.26	1.67	1.01
Mid Atlantic	-2.03	0.27	0.38	1.70	-0.03
South Atlantic	-1.06	0.84	0.18	0.87	0.75
East North Central	-1.43	0.48	0.17	1.11	0.49
East South Central	-0.49	0.96	0.08	0.79	1.45
West North Central	-0.84	0.34	-0.10	0.69	0.90
West South Central	-0.66	0.85	-0.07	0.68	0.97
Mountain	-0.87	0.22	0.11	0.50	0.58
Pacific	-1.12	0.95	0.32[3/]	0.43	2.16
Urban Hospitals	-1.43	0.73	0.19	1.05	0.97
0-99 Beds	-0.10	0.14	0.74	0.48	2.11
100-404 Beds	-0.74	0.85	0.13	0.89	1.87
405-684 Beds	-1.99	0.62	0.23	1.23	0.19
685 + Beds	-3.35	0.68	0.14	1.51	-1.20
Rural Hospitals	-0.16	0.07	0.06	0.46	0.56
0-99 Beds	-0.01	0.12	0.07	0.32	0.84
100-169 Beds	-0.02	0.05	-0.12	0.40	0.62
170 + Beds	-0.47	0.01	0.20	0.71	0.14

1/ These criteria were set forth in the September 3, 1985 final rule, but did not go into effect until May 1, 1986.

2/ This column includes the combined effects of all the previous columns, plus the statutory 0.5 percent increase to both standardized amounts and hospital-specific rates, plus the effect of implementation of the HCFA survey-based gross wage index.

3/ Oregon alone would receive payments based on 75 percent of the Federal rate and 25 percent of the hospital-specific rate, with a resulting payment increase of 3.24 percent.

TABLE III-ESTIMATED IMPACT OF PUB. L. 99-272 REVISIONS TO OPERATING COST PAYMENTS (EXCLUDING CAPITAL) FOR THE PERIOD MAY 1, 1986 TO SEPTEMBER 30, 1986, COMPARED TO OCTOBER 1, 1985 THROUGH APRIL 30, 1986 PAYMENTS BASED ON FY 1985 PAYMENT PARAMETERS

	Reduction in Teaching Adjustment Factor	Additional Payments to Disproportionate Share Hospitals	Change in Blend (55/45)	Revised Outlier Criteria 1/	Total Combined Effects 2/
Teaching Status					
Non-Teaching	-0.00	0.50	0.11	0.65	1.76
Resident/Bed Ratio Less than 0.25	-1.48	0.58	0.14	1.16	0.77
Resident/Bed Ratio 0.25 or Greater	-6.47	1.30	0.55	1.76	-2.98
Disproportionate Share Hospitals (DSH)					
No Additional Payments	-0.99	0.00	0.18	0.93	0.47
Urban DSH less than 100 Beds	-0.24	2.77	1.21	0.62	4.71
Urban DSH 100 Beds or More	-2.12	2.94	0.09	1.08	2.50
Rural DSH	-0.01	1.95	0.33	0.31	2.71
Other Special Status					
Sole Community Hospital (SCHs)	-0.04	0.08	-0.00	0.19	0.65
Rural Referral Centers (RRCs)	-0.89	0.05	0.65	0.75	0.45
Both SCH and RRC	-0.17	0.00	0.00	0.30	0.98
Type of Ownership					
Voluntary	-1.25	0.50	0.15	1.03	0.81
Proprietary	-0.20	0.72	0.03	0.51	1.67
Government	-1.76	1.20	0.38	0.84	0.88

1/ These criteria were set forth in the September 3, 1985 final rule, but did not go into effect until May 1, 1986.

2/ This column includes the combined effects of all the previous columns, plus the statutory 0.5 percent increase to both standardized amounts and hospital-specific rates, plus the effect of implementation of the HCFA survey-based gross wage index.

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We also analyzed the effect these changes, as a whole, made on the average payment per case for operating costs (excluding capital). To do this, we modeled each hospital's total operating payments according to its own fiscal year. These payments again were compared for two annualized periods: the baseline used the FY 1985 payment parameters in effect for the 7-month period from October 1985 through April 1986, and the comparison period used the payment parameters established under Pub. L. 99–272. Payments included additional payment for the costs of indirect medical education and disproportionate share payments, but excluded payments for capital-related costs, the direct costs of medical education, and other pass-through costs. The results are shown in Table VI., in section L. of this impact analysis, along with projected average payments per case for FY 1987.

G. Referral Center Criteria

There are currently 167 rural referral centers and one urban referral center. Those that qualified for referral center status in FY 1984 must requalify in FY 1987, for a new three-year period to begin in FY 1988, or lose their referral center status. The bulk of referral centers qualified during FY 1985, and will not have to requalify for a new three-year period until FY 1988.

The proposed criteria may enable some hospitals that could not meet the earlier discharge criteria to qualify in FY 1987. Under the specific criteria set forth in section 9106(a) of Pub. L. 99–272, we expect a small number of osteopathic hospitals to qualify, perhaps as few as two. Since hospitals in Massachusetts and New York State entered the prospective payment system only recently, we also expect some additional hospitals from those States to qualify for referral center status.

The initial qualification criteria for referral centers that qualified in FY 1984 included only hospitals with 500 beds or more. For the most part, those centers have met the qualifying criteria for at least two years since FY 1984, and should requalify in FY 1987. The proposed revision to the discharge criteria would minimize the possibility that a hospital would fail to requalify because of that criterion. A hospital would have to have qualified on the basis of the 6000 discharges criterion (or the regional urban median) and have experienced a greater than average decline in discharges to fail to requalify solely on the basis of that criterioon. Some hospitals may not be able to meet the proposed case-mix requirement. However, we believe these requirements are set at appropriate levels and are crucial to identifying those hospitals that truly function in a referral capacity.

H. Excluded Hospitals and Units

1. Target Amount Updates

As noted above, 738 Medicare hospitals and 1,598 units in hospitals included in the prospective payment system currently are paid on a reasonable cost basis subject to the rate-of-increase ceiling requirement of § 405.463. For cost reporting periods beginning in FY 1987, these hospitals would have a target amount equal to the 0.5 percent greater than the target amount for its previous cost reporting period. That is, the FY 1986 cost reporting period target amount, which was equal to the FY 1985 target amount increased by five-twenty-fourths of a percent in accordance with section 9101 of Pub. L. 99–272, would be multiplied by 1.005. As a result, excluded hospitals and units would be paid, in the aggregate, somewhat more than they would have been paid if the target amount included in the September 3, 1985 final rule had been implemented and carried forward for FY 1987.

The effect this would have on affected hospitals and units would vary depending on each one's existing relationship of costs per discharge to its target amount, and the relative gains in productivity (efficiency) the hospital or unit is able to achieve. For hospitals and units that achieve per discharge costs lower than their target amounts, the primary impact would be to affect the level of additional payments made under § 405.463(d)(2) proportional to the hospital's increase or decrease in per-discharge costs.

In general, we expect the increased ceiling on payments would maintain existing incentives for economy and efficiency experienced by excluded hospitals and units. We do not believe that these limits would achieve incentives comparable to those produced by the prospective payment system. Therefore, we will, as required under the law, continue to study means for establishing an appropriate prospective payment methodology for those hospitals and units that are currently excluded from the prospective payment system. Nontheless, we believe the proposed target amount level would ensure that services furnished to beneficiaries by affected hospitals and units would, for the most part, be paid for at a level no higher than necessary for the efficient delivery of needed health services.

2. Alcohol/Drug Hospitals and Units

In the September 3, 1985 final rule we extended the exclusion of alcohol/drug hospitals and units from the prospective payment system for an additional year (50 FR 35669). As of March 1986, there were 26 excluded alcohol/drug hospitals and 355 excluded units in PPS hospitals included in the prospective payment system. In June 1985, there were 23 hospitals and 317 units. Thus, there has been some increase in numbers over the additional extension period.

We do not expect that the further extension of this exclusion for one more year would result in a substantial increase in the number of participating alcohol/drug hospitals and units. Our study of the potential effects of the new DRGs proposed for these services is incomplete. Thus, we cannot predict the effect of bringing these hospitals and units under the prospective payment system.

I. DRG Classification Changes

Because we have attempted to respond as fully as possible to ProPAC's recommendations regarding DRG classification changes in addition to those we proposed on March 13, 1986, we have not yet modified the GROUPER program. Thus, we are unable to regroup claims in order to assess the impact of the proposed classification changes included in this proposed rule. We do not, however, expect the changes we are proposing for DRG classification to have a substantial impact on payment to any particular category of hospital, except possibly those hospitals specializing in treating cases that fall in affected DRGs.

The proposed DRG classification changes are intended to foster greater homogeneity within each DRG, or, when that is not possible, to ensure that the structure of a DRG is such that payment for the average case does not systematically advantage one group of hospitals at the expense of another. Because we evaluate the appropriateness of DRG classification changes in the aggregate, from the perspective of their ability to better explain variation in resource use across cases, and because most DRGs are defined broadly enough so that there is little concentration of cases in a given DRG among hospitals, we do not believe that an analysis of the economic impact of our proposed classification changes would reveal anything other than coincidental effects, particularly given the level of aggregation we generally work at.

J. Elimination of PIP

Approximately 3290 hospitals currently receive payments under the PIP method and would be affected by the proposal to eliminate PIP for discharges on or after July 1, 1987.

As a result of PIP, payments to PIP hospitals have been delayed less than reimbursement for non-PIP hospitals. Therefore, PIP hospitals have had a cash flow advantage over non-PIP hospitals. As a result of the elimination of PIP, the payment delay for hospitals presently under PIP could come to equal the current delay for current non-PIP hospitals. If this were to occur, our Medicare program outlays (as distinct from incurred expenditures) would be temporarily reduced. However, we anticipate that elimination of PIP would give current PIP hospitals incentives to speed up their billing process. Presently they have little incentive to speed up billing, or even to reduce any error rate, because timely payment is assured.

We anticipate that, in response to elimination of PIP, a hospital that does not currently file electronic media claims (EMC) would look at its own billing cycles and decide whether or not to bill through EMC. We expect that most hospitals have computer systems with the capability to submit claims electronically to the intermediary. At the present time our data show that 50 percent of all hospitals submit EMCs. We believe that the elimination of PIP would provide an incentive for more hospitals to convert to electronic claims.

For a hospital paid on a bill basis, billing errors may mean significant delay of payment. EMCs are prepared more easily by the hospital, with fewer errors than hardcopy claims. Additionally, EMCs are automatically entered into the intermediary's system, while hard copy bills must be individually typed. While data regarding average processing time under each method are not available, we believe that, in the absence of PIP, increased EMC could result in more rapid payment than under individual hard copy billing for some hospitals.

Hospitals with large numbers of patients with stays of 45 days and over may be slightly disadvantaged because only one interim payment per discharge would be allowed. Those hospitals having patients with unusually long lengths-of-stay may be slightly more disadvantaged if they have large numbers of patients falling between the end of the hospital's billing cycle and up to 45 days. We expect that the special interim payment for cases extending beyond 45 days would ease the impact of this proposal. However, this would apply only to payment for certain high-cost cases.

Monitoring and recomputation requirements under PIP, which occur not less often than quarterly, would be eliminated, as well as adjustment for PIP interim billing at cost settlement. Hence, we expect some administrative efficiencies. The data are not available to estimate the personpower and systems savings related to this activity.

K. Impact of Capital-Related Prospective Payments

1. Background

Section 601(a)2 of Pub. L. 98–21 and section 9107 of Pub. L. 99–272 authorize the Secretary to include, as hospital inpatient operating costs, capital-related costs for cost reporting periods beginning on or after October 1, 1986. By so doing, capital-related costs, which are currently reimbursed on a reasonable cost basis, would be incorporated into the prospective payment system. The hospital prospective payment rates would then include payments for these capital-related costs as well as for operating costs.

In our report to Congress entitled "Hospital Capital Expenses: A Strategy for the Future," we analyze the effects of the current system on hospital investment behavior and recommend that extension of the prospective payment system for capital-related costs would bring about a more rational and efficient distribution of capital resources. It also represents a less interventionist role for government and a much more market-oriented approach to the allocation of scarce resources than the current system. Based on our analysis of the industry, we believe it is an opportune time to revise our policy with respect to capital-related costs and subsume them under the prospective payment system.

By incorporating capital-related costs into the prospective payment system, we are extending the objectives underlying the current system to this area of inpatient hospital costs. Because capital costs remain fixed over an extended period of time, these types of expenditures generally do not correlate closely with variations in operating costs in the short-run. In a price-competitive market, however, capital-related costs will follow long-run charges in operating costs. Because we reimburse capital-related expenditures on a reasonable cost basis, hospitals have no strong economic incentive to conform their capital-related expenditures to the long-run patient market conditions of hospital operating characteristics. Thus, the principal objective we hope to achieve through integrating payments for inpatient capital-related costs into the prospective payment system is to establish the same kind of economic relationship between a hospital's operating costs and capital investment decisions as exist in price-competitive markets.

The difficulty in establishing a more price sensitive model for hospital capital investment decisions is the absence of a natural pricing mechanism that would serve to limit revenue sources for hospital capital investments. In fact, the current cost-based reimbursement system rewards hospitals through higher payments for investing in economically inefficient assets rather than for prudent purchasing and investment decisions. Rather than rewarding hospitals for investing in accordance with perceived market demand and the hospital's operating characteristics, the current cost-based reimbursement system rewards hospitals on the basis of their access to financial markets. For example, under cost-based reimbursement, a financially sound hospital with low utilization and with a low case-mix index can borrow funds for expansion of its plant even though it currently has surplus bed capacity. Under the current system, Medicare will reimburse these capital costs without regard to the prudence of the investment. Because of its higher capital costs, this hospital receives higher payments per discharge than a similar hospital with the same occupancy rate and case-mix index but which lacks the access to the financial market of the first hospital.

The proposal to establish prospective payment rates for inpatient hospital capital-related costs would establish a price that would result in hospitals accepting a certain degree of risk for their investment decisions. Incorporating payments for capital-related costs into the prospective payment system would subject these costs to the same financial and economic incentives to which operating costs are subject.

2. Expected Effects

Hospitals that either recently have or are about to make substantial commitments to building projects, either in the form of acquisitions or construction, could be adversely affected by this proposal. Building projects typically require long planning horizons and have long depreciable lives. Hence, hospitals that acquired major capital assets (for example, buildings and major fixed equipment)

and revalued these assets prior to the enactment of section 2314 of the Deficit Reduction Act of 1984 (Pub. L. 98–369), or that either are about to begin, are in the midst of, or completed construction of major capital projects within the past few years, may now be obligated to substantial long-term capital-related expenditures. As a result these hospitals may have above average capital related costs and therefore may be adversely affected by our proposal. Hospitals with low operating margins may experience some cash flow difficulties as a result of implementation of capital-related prospective payment rates, and may have to adopt one or more of the following measures:

- Reduce planned or current capital expenditures through modifying or eliminating current or planned capital acquisition or construction projects;
- Increase revenues through increasing charges or expanding into new markets by either offering new services or reaching new segments of the population;
- Begin or expand fund raising activities; or
- Accept reduction of historically experienced margins or revenue over costs.

We must point out, however, that our proposal provides a transition period during which time hospitals would be afforded an opportunity to adjust their capital planning and budgeting to meet the constraints of the new payment system. In this context, it is also appropriate to restate our intention to consider various alternative time tables for phasing in prospective capital-related payments and for computing payments. As stated in section II.D. of the preamble, we are seriously considering an alternative capital proposal which would deal separately with long-term capital (plant and fixed equipment) and shorter-term capital (movable equipment), with a long transition period to national rates for long-term capital and an immediate move to national rates for movable equipment. This structure might be combined with a rolling base for the hospital-specific portion of long-term capital and an exceptions pool to provide relief to hospitals meeting specified exception criteria. We estimate that adoption of a proposal such as this would likely reduce the estimated savings of the basic proposal by about 25–30 percent.

While some hospitals may be adversely affected by our proposed capital-related prospective payments, other hospitals with below average capital related costs may benefit from this proposal. Many publicly controlled hospitals have been under-capitalized in recent years because of budget constraints and low patient revenues. Because these hospitals typically have not been able to invest in new plant and equipment, their capital-related costs tend to be below average. Once the capital prospective payment rates are fully phased in, these hospitals may be benefited significantly because payments will be based on national average capital-related cost per discharge rather than the hospital's own capital-related costs. Whether these additional revenues would enable hospitals to invest in plant and equipment will depend on the hospital's cash flow needs. Hospitals experiencing serious operating deficits would most likely apply the additional payments to help reduce their operating deficits, while hospitals in a stronger financial position may use the additional revenues to finance capital projects.

We have analyzed, based on available data, the impact the proposed phase-in of capital payment rates would have on certain classes of hospitals over the four-year phase-in period, beginning in FY 1987. Table IV summarizes the results of this analysis. (The combined effects of the proposed capital rates and the updated prospective payment rates for operating costs (excluding capital) are discussed in section M. of this impact analysis.) Table IV displays the effects of implementing the proposed payment system over the four year transition period in terms of the percent change in payments levels between payment amounts approximating what hospitals would receive under the current system for FY 1987 and what they could expect to receive under Federal capital-related prospective payment rates. That is, we compared payments hospitals would receive assuming a 100 percent hospital-specific methodology for FY 1987 with the Federal portion of the prospective capital payment rates phased in over the proposed four year transition period. We used constant dollars and assumed no behavioral change. Thus, this table essentially displays a static analysis of the effect of the proposed transition period.

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TABLE IV - ESTIMATED IMPACT OF PHASE-IN OF PROPOSED CAPITAL PAYMENT SYSTEM COMPARED TO PRESENT SYSTEM OVER FOUR YEAR TRANSITION PERIOD (FY 1987-1991)

Percent Change for Total Capital Payments Based on Blend Portions[1/]

Federal Share / Hospital-Specific Share	20 percent[2/] 80 percent	40 percent[3/] 60 percent	60 percent 40 percent	80 percent 20 percent	100 percent 0 percent
All Hospitals	-4.43	-6.35	-8.28	-10.21	-12.15
By Census Regions					
New England	-2.79	1.42	3.14	4.85	6.57
Mid Atlantic	-3.88	-4.70	-6.08	-7.45	-8.83
South Atlantic	-4.46	-5.65	-7.15	-8.65	-10.15
East North Central	-3.79	-6.11	-8.14	-10.17	-12.19
East South Central	-5.33	-7.93	-10.71	-13.49	-16.27
West North Central	-5.79	-8.25	-11.13	-14.02	-16.90
West South Central	-5.60	-8.66	-11.58	-14.51	-17.44
Mountain	-6.29	-10.22	-12.60	-14.99	-17.37
Pacific	-3.26	-6.62	-8.77	-10.92	-13.07
Urban Hospitals	-4.08	-5.68	-7.32	-8.96	-10.60
0-99 Beds	-6.73	-8.54	-10.29	-12.04	-13.79
100-404 Beds	-5.49	-8.51	-11.54	-14.57	-17.60
405-684 Beds	-1.71	-1.36	-1.06	-0.75	-0.45
685 + Beds	-0.78	0.84	2.24	3.65	5.05
Rural Hospitals	-5.94	-9.25	-12.47	-15.70	-18.92
0-99 Beds	-5.80	-8.57	-11.30	-14.03	-16.76
100-169 Beds	-6.94	-11.53	-15.83	-20.14	-24.44
170 + Beds	-5.26	-8.11	-10.99	-13.88	-16.76

1/ Each column below represents a comparison of the total capital payments that would result from capital prospective payment rates composed of a blend of Federal and hospital-specific portions, both updated by the proposed 0.5 percent update factor, to the total capital payments that would result from capital rates that were 100 percent hospital-specific and updated by the projected capital market basket increase for FY 1987.

2/ For the first year (that is, FY 1987), the Federal rates are 50 percent of the national rate plus 50 percent of the regional rate, except for sole community hospitals.

3/ For FY 1988 and thereafter, Federal rates are 100 percent national, except for sole community hospitals.

NOTE: The assumptions used in this analysis differ from those in the President's Budget.

TABLE IV - ESTIMATED IMPACT OF PHASE-IN OF PROPOSED CAPITAL PAYMENT SYSTEM COMPARED TO PRESENT SYSTEM OVER FOUR YEAR TRANSITION PERIOD (FY 1987-1991)

Percent Change for Total Capital Payments Based on Blend Portions[1/]

Federal Share / Hospital-Specific Share	20 percent[2/] / 80 percent	40 percent[3/] / 60 percent	60 percent / 40 percent	80 percent / 20 percent	100 percent / 0 percent
Teaching Status					
Non-Teaching	-5.60	-8.52	-11.38	-14.24	-17.10
Resident/Bed Ratio Less than 0.25	-3.29	-4.38	-5.54	-6.70	-7.87
Resident/Bed Ratio 0.25 or Greater	-0.60	1.47	3.19	4.90	6.62
Disproportionate Share Hospitals (DSH)					
No Additional Payments	-4.97	-7.30	-9.66	-12.01	-14.37
Urban DSH less than 100 beds	4.36	9.41	15.10	20.79	26.48
Urban DSH 100 beds or more	-2.34	-2.70	-3.02	-3.34	-3.66
Rural DSH	-2.75	-4.02	-5.17	-6.32	-7.48
Other Special Status					
Sole Community Hospital (SCH)[4/]	-7.79	-7.79	-7.79	-7.79	-7.79
Rural Referral Center (RRC)	-1.82	-1.58	-1.38	-1.19	-0.99
Both SCH and RRC[4/]	-7.25	-7.25	-7.25	-7.25	-7.25
Type of Ownership					
Voluntary	-3.86	-5.38	-6.95	-8.52	-10.09
Proprietary	-10.15	-17.06	-23.90	-30.75	-37.59
Government	0.33	2.99	5.76	8.53	11.29

1/ Each column below represents a comparison of the total capital payments that would result from capital prospective payment rates composed of a blend of Federal and hospital-specific portions, both updated by the proposed 0.5 percent update factor, to the total capital payments that would result from capital rates that were 100 percent hospital-specific and updated by the projected capital market basket increase for FY 1987.

2/ For FY 1987, the Federal rates are 50 percent of the national rate plus 50 percent of the regional rate, except for sole community hospitals.

3/ For FY 1988 and thereafter, Federal rates are 100 percent national, except for sole community hospitals.

4/ Sole community hospitals will be paid 75 percent of their hospital-specific rate plus 25 percent of their Federal regional rate for FY 1987 and thereafter.

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In computing the capital prospective payment rates, we removed from the rates 100 percent of the interest earned on funded depreciation and adjusted the rates for the effect of outlier payments. We used the capital component of the hospital market basket to project hospital-specific capital costs through FY 1987. The Federal and hospital-specific portions of the proposed capital rates both were updated by the proposed prospective payment update factor of 0.5 percent.

If FY 1987 capital-related payments were based solely on the Federal rates, all hospitals under the prospective payments system could expect, on the average, a 12.15 percent payment reduction compared to their FY 1984 capital costs updated through FY 1987 by the capital component of the market basket. To the extent that capital costs increased more slowly than the capital component for a particular hospital or category of hospitals, the impact would be lessened. The overall reduction over the phase-in period reflects the combined effect of removing interest on funded depreciation and the different factors used to update hospitals' capital-related costs and the prospective capital-related payment rates for FY 1987. Hence, one can conclude the categories of hospitals with less than a 12.15 percent estimated reduction in payments have, on the average, capital-related costs that are lower than average. Conversely, hospitals sustaining a greater reduction in their capital-related payments have higher than average costs.

Although capital-related payments would decline overall under the proposed payment system, there are some notable exceptions to this trend. Small, urban, disproportionate share hospitals could expect a nearly 26.5 percent increase in their capital-related payments compared to their 1984 capital-related costs updated by the capital component of the market basket. This represents the largest gain of any hospital group. Other categories of hospitals that would benefit from the proposed system are publicly controlled (government) hospitals, hospitals heavily involved in teaching programs, and large, urban hospitals. On average, these hospitals could expect to receive a significant increase in capital-related payments. Also, hospitals in the New England census division could expect to receive, on the average, higher payments for capital-related expenditures. To the extent that a hospital's capital related costs increased faster than the capital component of the market basket, the hospital would benefit less.

Among those categories of hospitals that would sustain reductions in revenues under the proposed system, proprietary hospitals would be the most severely affected group. The extreme drop in payments to proprietary hospitals, we believe, reflects their generally heavier and more recent investments in major capital assets, compared to other hospital assets than other types of hospitals.

Rural hospitals in general would receive lower payments, and the second most severely affected hospital category, after proprietary hospitals, would be rural hospitals with between 100 and 169 beds. The major factors contributing to the reduced rates for these hospitals, we believe, are low occupancy levels and the effect of outlier payment adjustments.

On the whole, rural hospitals would experience a greater drop in capital-related revenues under the proposed system than would urban hospitals. On average, if the proposed Federal capital rates were imposed in full in FY 1987 all rural hospitals would see almost a 19 percent decline in payments relative to their FY 1984 capital-related costs updated by the capital component of the market basket through FY 1987, while urban hospitals, on the average, would experience less than an 11 percent decline compared to their FY 1984 capital-related costs updated through FY 1987. However, urban hospitals with between 100 and 404 beds would experience reductions comparable to rural hospitals.

Although the New England Region would experience some disadvantage for the first year of the phase-in, when regional and hospital-specific rates would depress payments, over the long run it is the one geographical area that would benefit the most from the proposed revamping of the capital-related payment system. The West South Central and Mountain regions of the country would be the most adversely affected areas. This may be the result of a large number of small rural hospitals being concentrated in those regions.

L. Updated Payment Rates and Resulting FY 1987 Payment Amounts

The addendum to this proposed rule, which is printed after the text of the proposed regulation changes and which precedes the appendices, sets forth the proposed methodology for computation of FY 1987 standardized amounts and includes tables of the proposed Federal national and regional rates, DRG relative weights, and outlier thresholds. In this section we present an analysis of the impact of those proposed payment rates. The combined effect of these rates and the proposed capitol rates is discussed in section M. of this impact analysis.

Many of the proposed changes to hospital prospective payments for FY 1987 result from changes required under sections 1886 (d) and (e) of the Act as amended by sections 9101 through 9105 of Pub. L. 99–272. The following changes are required under the statute as currently amended:

- Effective with cost reporting periods beginning in FY 1987, except for hospitals located in Oregon and for sole community hospitals, hospital prospective payment rates will be the sum of 75 percent of the Federal rates and 25 percent of a hospital-specific rate (section 1886(d)(1)(C) of the Act);
- For discharges occuring on or after October 1, 1986, (with the exception of discharges from sole community hospitals and hospitals located in Oregon), the Federal portion of the prospective payment rates will be comprised of 50 percent of the national standardized amount and 50 percent of the appropriate regional standardized amounts, per section 1886(d)(1)(D) of the Act;
- The hospital costs used to establish the rates will be restandardized to reflect the indirect costs of medical education as measured by the revised indirect medical education adjustment factor and to reflect payment adjustments to disproportionate share hospitals per sections 1886(d)(2)(C) (i) and (iv) of the Act as amended by sections 9104(b) and 9105(b) of Pub. L. 99–272; and
- The standardized amounts will be adjusted, by the indirect medical education payment equality factor, to reflect the savings from the change in the indirect medical education adjustment, as required under section 1886(d)(3)(C)(iii) of the Act, as added by section 9104(b) of Pub. L. 99–272.

In addition to reflecting changes required under the Act, the proposed hospital payment rates reflect changes we are proposing, some as a result of changes in the industry, in response to the prospective payment system and other influences, some as a result of more accurate data. We are proposing the following additional changes under general authority granted the Secretary in the prospective payment statute:

- A 0.5 percent update factor for both the Federal and hospital-specific rates (see section II.A.3.f. of the Addendum);
- A revised and rebased market basket, which results in different weights for the labor and non-labor components of the market basket (see section III of the preamble and

Appendix A of this document for a detailed discussion); and

• The incorporation of the HCFA gross wage index into the restandardization of the Federal amounts and for computing the prospective payment rates (see section II.A.2. of the addendum).

Table IV summarizes the separate and combined effects of those of the above provisions that are estimable using available data. As noted above, changes often interact in complex ways, not simply multiplicatively or additively. The percent changes reflected below include total payments for operating costs (excluding capital), payments for the indirect costs of medical education, and additional payment for outlier cases and to disproportionate share hospitals.

The proposed FY 1987 prospective payments for capital are excluded to allow comparison with estimated FY 1986 payments. (See section M. of this impact analysis for a discussion of the combined effects of these rate changes and the proposed capital payments.) Direct medical education payments are also excluded. All hospitals are assumed to have the same cost reporting period, corresponding to the Federal fiscal year. The column titled "Total Combined Effects" includes the effects of the proposed 0.5 percent update factor.

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TABLE V--ESTIMATED IMPACT OF PROPOSED REVISIONS OF PAYMENTS FOR OPERATING COSTS (EXCLUDING CAPITAL) FOR FY 1987 COMPARED TO FY 1986 RATES FOR THE PERIOD MAY 1, 1986 TO SEPTEMBER 30, 1986

	New Labor/ Nonlabor Portion	New Standardized Amounts (Federal Rates)1/	Combined Effect of Portion & Rate Changes2/	Blend Change (75/25)	Total Combined Effects3/
All Hospitals	0.03	-0.45	-0.44	0.64	0.53
By Census Regions					
New England	-0.00	-0.01	-0.01	0.68	0.96
Mid Atlantic4/	0.02	-0.00	-0.01	1.64	1.88 4/
South Atlantic	0.10	-0.66	-0.60	0.72	0.57
East North Central	0.02	-0.33	-0.33	-0.39	-0.42
East South Central	0.10	-0.78	-0.70	1.61	1.44
West North Central	0.04	-0.30	-0.29	0.33	0.41
West South Central	0.08	-0.70	-0.65	0.41	0.21
Mountain	0.01	-0.18	-0.20	1.17	1.29
Pacific	-0.08	-0.74	-0.85	1.13 5/	0.45
Urban Hospitals	0.01	-0.50	-0.52	0.73	0.53
0-99 Beds	0.05	-0.62	-0.60	2.87	2.59
100-404 Beds	0.02	-0.50	-0.51	0.92	0.72
405-684 Beds	0.02	-0.48	-0.49	0.47	0.30
685 + Beds	-0.06	-0.48	-0.57	-0.19	-0.45
Rural Hospitals	0.13	-0.20	-0.09	0.16	0.55
0-99 Beds	0.01	-0.09	-0.10	0.51	0.88
100-169 Beds	0.10	-0.20	-0.11	-0.57	-0.21
170 + Beds	0.32	-0.36	-0.07	0.30	0.73

1/ This column shows the combined effects of restandardization of base year cost data and adjustment of the standardized amounts by the indirect medical education payment equality factor.

2/ This column shows the combined effects of the first two columns.

3/ This column includes the effect of the proposed 0.5 percent update factor, and assumes that outlier criteria remain unchanged.

4/ The Federal regional rates for the Mid-Atlantic region reflect the adjustment of base year costs to recognize the effects of a revised sequence of cost allocation for certain teaching hospitals. This change and the corresponding effects on hospital-specific rates and payments for the indirect costs of medical education are reflected in the projected payments for hospitals in that region.

5/ Oregon alone would receive payment based 100 percent of the Federal national rate, with a resulting payment increase of 4.65 percent.

TABLE V--ESTIMATED IMPACT OF PROPOSED REVISIONS OF PAYMENTS FOR OPERATING COSTS (EXCLUDING CAPITAL) FOR FY 1987 COMPARED TO FY 1986 RATES FOR THE PERIOD MAY 1, 1986 TO SEPTEMBER 30, 1986

	New Labor/ Nonlabor Portion	New Standardized Amounts	Combined Effect of Portion & Rate Changes	Blend Change (75/25)	Total Combined Effects 1/
Teaching Status					
Non-Teaching	0.06	-0.46	-0.43	0.76	0.71
Resident/Bed Ratio Less than 0.25	0.03	-0.45	-0.45	0.44	0.31
Resident/Bed Ratio 0.25 or Greater	-0.09	-0.38	-0.50	0.68	0.44
Disproportionate Share Hospitals (DSH)					
No Additional Payments	0.03	-0.40	-0.40	0.49	0.43
Urban DSH less than 100 Beds	0.06	-0.86	-0.83	6.05	5.55
Urban DSH 100 Beds or More	0.04	-0.63	-0.62	1.10	0.81
Rural DSH	0.07	-0.18	-0.12	1.99	2.41
Other Special Status					
Sole Community Hospital (SCHs)	0.00	-0.07	-0.07	-0.00	0.43
Rural Referral Centers (RRCs)	0.47	-0.56	-0.12	2.00	2.38
Both SCH and RRC	0.18	-0.24	-0.07	0.00	0.42
Type of Ownership					
Voluntary	0.03	-0.41	-0.41	0.48	0.40
Proprietary	-0.00	-0.62	-0.65	0.66	0.37
Government	0.07	-0.52	-0.48	1.61	1.55

1/ This column shows the combined effects of restandardization of base year cost data and adjustment of the standardized amounts by the indirect medical education payment equality factor.

2/ This column shows the combined effects of the first two columns.

3/ This column includes the effect of the proposed 0.5 percent update factor, and assumes that outlier criteria remain unchanged.

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Each of the proposed changes has somewhat different distributive effects. The change in labor and nonlabor portions of the standardized amounts for operating costs (excluding capital) would benefit rural hospitals, as a whole, much more than urban hospitals. However, it would not significantly benefit rural hospitals with less than 100 beds. The only categories of hospitals that would experience a significant disadvantage from this proposed change would be the largest urban hospitals, hospitals with major teaching involvements, and hospitals in the Pacific region. The first two of the categories undoubtedly overlap to a large extent.

The restandardized adjusted standardized amounts result in lower payments for all categories of hospitals. There is a wide range of effects on different census regions, with the New England and Mid-Atlantic regions experiencing negligible effects, while the South Atlantic, East South Central, West South Central, and Pacific regions experience more adverse effects.

Interestingly, the category of hospitals most adversely affected by the restandardization and adjustment of the new Federal rates is disproportionate share hospitals with less than 100 beds. This appears to be the only change we are proposing that would affect this category adversely; they are the category most benefited by both the proposed capital prospective payments and the change of blend. (As can be seen in Table VII of section M. of this impact analysis, they are the only category projected to increase their Medicare profit margin for FY 1987.) This is a small group of hospitals, comprising less than one percent of all Medicare participating hospitals included in the prospective payment system. Apparently, their average hospital-specific costs, both for capital-related costs and operating costs excluding capital, are significantly below the national average. Thus, any change that would pay these hospitals an amount per case closer to the national average cost per case benefits them significantly.

Nationally, the great majority of hospitals would receive increased FY 1987 payments for their operating costs (excluding capital) as a result of these proposals. Geographically, only the East North Central region would decline, as a whole. The largest urban hospitals and medium-sized rural hospitals also would be somewhat disadvantaged.

The greatest overall payment increases would accrue to the Mid-Atlantic, East South Central, and Mountain regions. Other than the small urban disproportionate share hospitals already discussed, the categories of hospitals most benefiting would be the larger group of all urban hospitals with less than 100 beds, disproportionate share rural hospitals, and rural referral centers.

In addition to reviewing the effects of these proposals on total operating cost payments, we considered their effect on average payment per case, as we did for the FY 1986 changes discussed in section F. of this impact analysis. This enabled us to reflect the practical effect of hospitals phasing into the prospective payment system on the basis of their own cost reporting periods. Table VI shows the comparative average payment rates for FYs 1986 and 1987, compared to the baseline average payments per case for the period from October 1, 1985 to April 30, 1986. As can be seen, the national average payment per case continues to increase.

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TABLE VI--COMPARISON OF ESTIMATED OPERATING PAYMENTS PER CASE
(EXCLUDING CAPITAL AND CASE-MIX INCREASES)

	Average Payment Per Case		
	Baseline Period	FY 1986	FY 1987
All Hospitals	$3,843.78	$3,854.01	$3,880.20
Urban			
New England	4,187.06	4,203.20	4,261.40
Mid Atlantic	4,267.20	4,259.15	4,300.34
South Atlantic	3,548.63	3,557.22	3,583.90
East North Central	4,148.24	4,151.58	4,130.62
East South Central	2,877.69	2,891.98	2,942.78
West North Central	3,458.51	3,468.94	3,489.24
West South Central	3,371.34	3,383.11	3,403.53
Mountain	3,749.78	3,753.85	3,790.37
Pacific	4,814.71	4,848.99	4,915.44
Urban Hospitals	4,331.05	4,343.55	4,373.45
0-99 Beds	3,260.70	3,280.00	3,368.40
100-404 Beds	4,029.55	4,055.87	4,110.29
405-684 Beds	4,750.25	4,748.57	4,748.61
685 + Beds	5,480.30	5,451.04	5,392.61
Rural Hospitals	2,475.64	2,479.51	2,495.29
0-99 Beds	2,187.12	2,192.64	2,214.82
100-169 Beds	2,525.14	2,530.68	2,536.38
170 + Beds	2,940.73	2,940.03	2,954.23

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TABLE VI--COMPARISON OF ESTIMATED OPERATING PAYMENTS PER CASE
(EXCLUDING CAPITAL AND CASE-MIX INCREASES)

	Average Payment Per Case		
	Baseline Period	FY 1986	FY 1987
Teaching Status			
Non-Teaching	3,234.47	3,254.38	$3,297.37
Resident/Bed Ratio Less than 0.25	4,514.45	4,524.30	4,543.34
Resident/Bed Ratio 0.25 or Greater	6,816.92	6,725.22	6,608.94
Disproportionate Share Hospitals (DSH)			
No Additional Payments	3,736.08	3,739.51	3,753.00
Urban DSH less than 100 Beds	2,981.62	3,026.51	3,210.12
Urban DSH 100 Beds or More	4,476.87	4,517.60	4,598.13
Rural DSH	1,961.57	1,980.43	2,043.38
Other Special Status			
Sole Community Hospital (SCHs)	2,788.76	2,793.22	2,811.98
Rural Referral Centers (RRCs)	3,295.27	3,294.80	3,351.22
Both SCH and RRC	3,199.79	3,208.54	3,235.34
Type of Ownership			
Voluntary	4,019.51	4,029.14	4,052.01
Proprietary	3,562.42	3,582.47	3,613.00
Government	3,212.26	3,218.74	3,259.94

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M. Combined Impact of Proposed FY 1987 Prospective Payment Rates for Operating and Capital-Related Costs

As discussed in section II.A.3.f. of the Addendum to this proposed rule, operating margins of hospitals appear to have increased significantly under the prospective payment system. It is not our intention or our responsibility to determine what specific levels of hospital margins may be appropriate. Nonetheless, individual hospitals will assess the impact of these proposals on themselves largely in terms of the anticipated effects on the projected relationships of their FY 1987 revenues to their FY 1987 costs. The proposed inclusion of capital under the prospective payment system makes this of special concern to affected hospitals this year.

Based on available data, we have done our best to consider what the combined effects of these proposals would be on hospital profit margins for payments and costs related to services for Medicare beneficiaries. There are some limitations in the data and methodology that require us to view the results with caution, but we believe that they nonetheless throw significant light on the magnitude of anticipated overall effects of these proposals. Table VII shows the projected changes in Medicare total payments and profit margins from FY 1986 to FY 1987, taking into consideration payments for both capital-related costs and operating costs excluding capital. To estimate these margins, we had to estimate Medicare-related revenues and costs (excluding revenues and costs related to the direct costs of medical education) for each fiscal year, and compute the differences. To estimate costs, we used FY 1984 cost report data, must of which is unaudited, and brought it forward to the appropriate fiscal year basis using the hospital market basket.

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TABLE VII.--COMPARISON OF ESTIMATED FY 1986 AND FY 1987 TOTAL MEDICARE PAYMENTS AND PROFIT MARGINS - SELECTED CATEGORIES OF HOSPITALS

	Percent Payment Difference 1/ (FY 1987/FY 1986)	Estimated FY 1986 2/ Profit Margin	Estimated FY 1987 3/ Profit Margin
All Hospitals	-0.36	17.1	12.8
By Census Regions			
New England	0.32	10.7	7.3
Mid Atlantic	0.88	18.7	15.8
South Atlantic	-0.42	14.3	10.1
East North Central	-1.11	18.0	12.8
East South Central	0.25	11.1	7.7
West North Central	-0.63	19.1	14.4
West South Central	-0.87	19.7	14.8
Mountain	0.16	17.3	13.7
Pacific	-0.26	21.2	16.9
Urban Hospitals	-0.35	18.9	14.6
0-99 Beds	1.17	17.7	15.2
100-404 Beds	-0.31	17.8	13.6
405-684 Beds	-0.38	20.1	15.6
685 + Beds	-1.10	21.7	16.4
Rural Hospitals	-0.43	9.2	5.1
0-99 Beds	-0.07	10.2	6.5
100-169 Beds	-1.20	9.5	4.7
170 + Beds	-0.27	7.5	3.7

1/ This column shows the projected change in total payments, including operating and capital costs, disproportionate share payments, indirect medical education payments, and outlier payments, but excluding payments for the direct costs of medical education.

2/ Estimated for a hypothetical full year of payments using the payment parameters in effect from May 1, 1986 through September 30, 1986.

3/ Projected for a hypothetical full year of payments with an 0.5 percent update factor applied to operating cost standardized amounts (labor, nonlabor, and capital components) and both the operating cost (excluding capital) and capital-related hospital-specific portions. All projected costs were inflated using the projected hospital market basket. All hospitals were assumed to have the same cost reporting period, corresponding to the Federal fiscal year.

TABLE VII -COMPARISON OF ESTIMATED FY 1986 AND FY 1987 TOTAL PAYMENTS AND PROFIT MARGINS - SELECTED CATEGORIES OF HOSPITALS

	Percent Payment Difference 1/ (FY 1987/FY 1986)	Estimated FY 1986 2/ Profit Margin	Estimated FY 1987 3/ Profit Margin
Teaching Status			
Non-Teaching	-0.34	14.9	10.8
Resident/Bed Ratio Less than 0.25	-0.49	19.3	14.8
Resident/Bed Ratio 0.25 or Greater	-0.02	21.9	17.8
Disproportionate Share Hospitals (DSH)			
No Additional Payments	-0.50	16.0	11.6
Urban DSH less than 100 Beds	4.83	22.3	23.9
Urban DSH 100 Beds or More	0.03	21.7	17.7
Rural DSH	1.54	12.1	10.0
Other Special Status			
Sole Community Hospital (SCHs)	-0.06	7.9	4.2
Rural Referral Centers (RRCs)	1.47	14.5	12.4
Both SCH and RRC	-0.16	12.7	8.9
Type of Ownership			
Voluntary	-0.43	17.8	13.4
Proprietary	-1.30	14.6	9.5
Government	0.93	16.0	13.2

1/ This column shows the projected change in total payments, including operating and capital costs, disproportionate share payments, indirect medical education payments, and outlier payments, but excluding payments for the direct costs of medical education.

2/ Estimated for a hypothetical full year of payments using the payment parameters in effect from May 1, 1986 through September 30, 1986.

3/ Projected for a hypothetical full year of payments with an 0.5 percent update factor applied to operating cost standardized amount (labor, nonlabor, and capital components) and both the operating cost (excluding capital) and capital-related hospital-specific portions. All projected costs were inflated using the projected hospital market basket. All hospitals were assumed to have the same cost reporting period, corresponding to the Federal fiscal year.

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As can be seen, in the aggregate, we estimate that all of these selected categories of hospitals would show some margin of profit. Of course, not all individual hospitals have profits now, or will have profits in FY 1987. Table VIII shows the same comparisons as Table VII, broken down by payment cells, rather than by selected categories of hospitals. This analysis shows that rural hospitals in the South Atlantic region may experience, in the aggregate, an excess of costs over revenues in FY 1987.

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TABLE VIII--COMPARISON OF ESTIMATED FY 1986 AND FY 1987 TOTAL PAYMENTS AND PROFIT MARGINS - HOSPITALS BY PAYMENT CELL

	Percent Payment Difference 1/ (FY 1987/FY 1986)	Estimated FY 1986 2/ Profit Margin	Estimated FY 1987 3/ Profit Margin
All Hospitals	-0.36	17.1	12.8
Urban	-0.35	18.9	14.6
New England	0.41	10.7	7.4
Mid Atlantic	1.08	18.9	16.2
South Atlantic	-0.39	17.0	12.7
East North Central	-1.08	19.2	14.0
East South Central	0.54	15.1	12.0
West North Central	-0.65	24.3	19.5
West South Central	-1.14	22.1	16.8
Mountain	0.10	20.1	16.3
Pacific	-0.35	21.6	17.2
Rural	-0.43	9.2	5.1
New England	-0.58	10.9	6.5
Mid Atlantic	-0.80	17.1	12.4
South Atlantic	-0.53	3.6	-0.3
East North Central	-1.27	11.8	6.7
East South Central	-0.34	3.8	0.0
West North Central	-0.60	9.1	4.9
West South Central	0.18	11.3	7.8
Mountain	0.33	10.5	7.2
Pacific	0.97	16.3	13.5

N. Quality of and Access to Care

As we have stated on other occasions, the prospective payment system endeavors to change hospital behavior through financial incentives. While our goals are largely economic, we are also acutely concerned that for some hospitals economic considerations might, in some cases, overshadow their concerns for the quality of care delivered and maintaining access to appropriate services and levels of services for Medicare beneficiaries.

We believe that the incentives to increase the efficiency with which inpatient services are provided to Medicare patients should not conflict with established quality of care standards and access to needed services. Many hospitals have responded to the prospective payment system by eliminating marginally profitable services with low utilization. This has enabled them to concentrate their resources (both medical and managerial) by specializing in those services and types of cases that the hospitals are best equipped to treat. By focusing their efforts on specific types of cases it appears that hospitals have achieved economic gains, while at the same time improving the quality of care provided to patients. Through specialization, medical personnel are able to refine their medical knowledge and skill in providing better care. For instance, open heart surgery is a well-documented example of the direct relationship between the number of procedures performed and the increased chances of a successful outcome from such a procedure.

At the same time that specialization results in better care for patients, it also generally results in lower costs. First, through repeated encounters with the same types of cases, hospital staffs learn the most effective and efficient treatment methods, thus improving the chances of a successful outcome with a minimum of wasted effort and resources. Secondly, as patient utilization increases, costs per case usually decline as a result of economies of scale. Thus, we expect that the prospective payment system can provide a stimulus for improving quality of care by fostering more rational and market oriented approaches to the treatment of patients that also result in lower costs for the Medicare program.

As discussed in section II.A.3.f. of the Addendum to this proposed rule, we have not found any systematic evidence of compromise or deterioration in the quality of or access to inpatient hospital care under the prospective payment system. Nonetheless, we are mindful of those cases involving inappropriate care that have been identified through the efforts of Utilization and Quality Control Peer Review Organizations (PROs) or brought to our attention through other sources. While the confirmed number of cases involving substandard or inappropriate care is small compared to the total number of Medicare patients discharged from hospitals each year, they have attracted considerable attention from both Congress and the public. The Office of the Inspector General and HCFA have thoroughly investigated all cases brought to our attention to determine the magnitude of the problems, their causes, and efforts taken to correct them.

Of the more than 4000 cases involving substandard or inappropriate care that we have investigated, we have found no evidence indicating systematic mistreatment of Medicare patients under the prospective payment system. While it is true that average lengths of stay have declined under the prospective payment system, and a greater number of patients are being treated in nonhospital settings, these changes, by themselves, do not indicate poorer quality care. Our concern, however, for ensuring that economic interests do not compromise quality care has led us to develop a number of short-and long-range initiatives directed at identifying and correcting immediate problems while engaging in studies of fundamental policy issues that could influence quality of care over the long haul.

As part of our initiative to improve PRO surveillance of hospital and physician treatment of Medicare patients, we have been reviewing our experience from the first two years of PRO review. This has led us to refine PRO efforts in the area of quality of care and further to focus review on poor performing providers and practitioners. Every case a PRO reviews, whether or not it is explicitly part of a quality review, will be subjected to a "generic" quality review. This will involve an examination of several key medical indicators that we believe reflect the quality of care provided to the patient. A "generic" review may include reviewing the patient's medical records to determine the medical stability of the patient at time of discharge, adequacy of discharge planning, or unscheduled return to surgery. These new quality of care requirements will be incorporated into PROs' contracts for their next contract cycle. We also plan to expand review of apparently premature discharges so that we can more easily detect inappropriate discharges and transfers.

In addition to improving the process for identifying substandard or inappropriate care through modifying the PROs' scope of work, we will be strengthening our efforts to correct problems of poor quality whenever violations of accepted medical practice standards are discovered. Corrective action may range from education of the individual physician or hospital, to intensified review, or to payment denials where actions are taken to circumvent the prospective payment system, or if otherwise appropriate. As a final measure, we are prepared to exclude serious or repeat offenders from the Medicare program entirely.

In order to ensure that PROs conduct reviews in accordance with HCFA contracts, we have contracted with Systemetrics, a leading firm in the area of quality of care assessments, to act as a "super PRO". Systemetrics will monitor PRO review activities and validate PROs' medical determinations and identify PRO performance issues.

In many respects, beneficiaries who are informed of their rights under the prospective payment system can help us to assure that providers and physicians furnish appropriate care. While beneficiaries may not be able to prevent abuses or poor quality care, they can assist PROs in their medical oversight responsibilities by filing appeals or contacting the PRO when they believe that either the hospital or physician has acted improperly. Also, providers and physicians are less likely to provide substandard care to beneficiaries who are informed of their rights. In our efforts to educate beneficiaries of their rights, we are conducting outreach programs and requiring hospitals to inform beneficiaries at the time of admission of their rights under Medicare and how to contact the local PRO should the need arise.

Improving the PRO review methodology is a central feature of our effort for assuring high standards of medical care. Nevertheless, we are developing initiatives in other areas that we expect will have long-range systemic effects on the quality of care furnished in all settings. For example, we are pursuing more aggressive Federal oversight of State survey and certification of hospitals, skilled nursing facilities, home health agencies and other types of health care facilities. Finally, to gain a better grasp of the broader long-term quality of care issues affecting all beneficiaries and those specific to certain groups of

beneficiaries, we have contracted with several major research organizations to conduct studies related to quality, for example, on outcomes of surgery in the Medicare aged population, the health status of beneficiaries at time of discharge, and an evaluation of the quality effects of the prospective payment system on beneficiaries suffering from End Stage Renal Disease.

These initiatives represent our own efforts to monitor and evaluate the impact of the prospective payment system on quality of care. There are, however, numerous other monitoring and inspection programs carried out by other Federal agencies, State and local governments and private organizations. For example, the Food and Drug Administration sets standards for radiation exposure levels from imaging and therapy equipment, while State health departments monitor compliance with licensure requirements. The Joint Commission on Accreditation of Hospitals and the American Osteopathic Hospital Association set general operating standards for member hospitals that we accept as sufficient for participation in the Medicare and Medicaid programs. The combined efforts of all these private and governmental bodies all help establish appropriate standards of patient care and serve as a network to see that these standards are maintained.

Although the trust of the prospective payment system is explicitly directed at payment reform, we are deeply concerned and mindful of our responsibility to safeguard the quality of care beneficiaries receive under the aegis of the Medicare program. We have been unrelenting in our efforts to ensure that providers and practitioners do not use the prospective payment system as an excuse to increase the risk to patients' health and safety beyond accepted standards of care. We believe that most providers and practitioners have not compromised the quality of care they provide. The few that have or that may in the future try to economize at the expense of patients' safety will be dealt with appropriately. We believe that most breaches of medical treatment standards are the result of unintentional errors or unfamiliarity with accepted norms and medical practice. Corrective action in these cases usually entails educating the offending institution or practitioner as to the appropriate method or standard of treatment. Other more serious offenses will require more strenuous corrective action. The Office of the Inspector General has agreed to coordinate its investigative efforts with the PROs to identify serious and repeated violations of the Medicare law and of accepted medical standards. We are confident that our efforts to identify and correct immediate problems will eliminate the majority of cases involving inappropriate care. Our initiatives to investigate long-term quality of care issues will enable us to refine our payment policies so as to more precisely target those areas that require special attention.

O. Alternatives Considered

Throughout the discussions in the preamble and this analysis, we have explained why we are proposing to do one thing rather than another. Many interrelated decisions are involved in this process, and the number of possible combinations of different DRG weights, different update factors, and other proposals is large. Further, there are additional alternatives that had to be considered in developing the proposed DRG classification changes, the proposed capital rates, and the update factor for the proposed Federal rates. Altogether, there is a potentially enormous number of permutations.

Nonetheless, we have been particularly concerned with the impact of certain main options, and we have reviewed them in the light of how they would interact with each other. We also considered all the ProPAC recommendations. Each of the factors taken into consideration in the development of the proposed FY 1987 standardized amounts has been reviewed both individually and in combination with other factors.

P. Summary and Conclusions

E.O. 12291 requires us to assess the benefits, costs and net benefits of all rules, major or otherwise. For major rules, we must discuss those costs and benefits in impact analyses, and show that the potential benefits outweigh the potential cost to society. In addition, we must discuss alternative methods of achieving the objectives we propose in our regulations. Throughout the preamble, addendum, and this impact analysis, such alternatives are discussed. In this summary, we assess the overall costs of the proposals we are making, the overall benefits, and the resulting net benefits.

For the most part, the costs and disadvantages that could result from these proposals would take the form of limiting the amount of payment to affected hospitals. Most of the proposals would have their major effect through their influence on the level of FY 1987 prospective payments.

As we have said before, the primary benefit expected to result from this proposed rule is the maintenance and effective management of the prospective payment system itself. The incentives of this system are expected to produce substantial benefits in the form of economy and efficiency of operation of participating hospitals, and as improvements in trends of the health care marketplace as a whole. As noted earlier, the objective of these proposals is to refine the prospective payment system. Whereas the system as a whole has had a large and dramatic impact, the proposed refinements, with the exception of the proposal to include capital-related costs under prospective payment rates, generally are of a marginal nature, rather than large-scale adjustments.

We believe that, from this perspective, the overall benefits to society more than offset any resulting liabilities. For the above reasons, we believe that this analysis meets the objectives of E.O. 12291 and the Regulatory Flexibility Act, as noted in the Introduction to this Regulatory Impact Analysis.

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APPENDIX C

PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

APRIL 1, 1986

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, D.C. 20402

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April 1, 1986

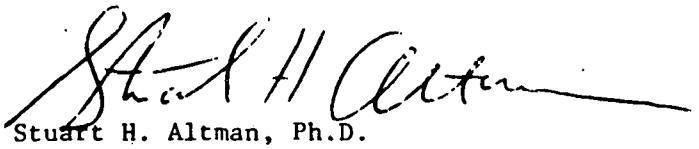
Honorable Otis Bowen, M.D.
Secretary
Department of Health and Human Services
Washington, D.C. 20101

Dear Secretary Bowen:

I am pleased to transmit to you the second annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(4) of the Social Security Act as amended by Public Law 98-21. This report contains thirty-three recommendations updating the Medicare prospective payments and modifying the diagnosis-related group (DRG) classification and weighting factors.

The report also provides background on the Commission's priorities as well as an indication of its agenda for coming years.

Sincerely,



Stuart H. Altman, Ph.D.
Chairman

Enclosure

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* The Report Appendix is not reprinted in the Federal Register.

Executive Summary

In its April 1986 report, the Prospective Payment Assessment Commission (ProPAC) conveys its recommendations to the Secretary of the Department of Health and Human Services (HHS) on ways to update and improve the Medicare prospective payment system (PPS). The 33 recommendations reflect the key concerns of ProPAC's 15 commissioners. The proposed changes are necessary, in the Commission's view, to maintain access to high-quality health care, encourage hospital productivity and long-term cost-effectiveness, and facilitate innovation and appropriate technological change.

This summary highlights the major areas addressed in the recommendations.

Update Factor.—The Commission estimates that its update factor recommendation would result in a 2.8 percent increase in hospital payment per case for fiscal year 1987. That figure is derived from combining several components. These are: 1) increases for inflation in the hospital market basket (adjusted for forecast errors), scientific and technolgical advances in the hospital industry, and real case-mix changes; and 2) decreases for changes in hospital productivity, shifts in site of service, and reported changes in the case-mix index.

Sharing of Gains.—The Commission believes that hospitals, beneficiaries, and the Medicare program should share gains achieved under PPS. In this connection, the Commission urges legislative change in the formula determining Medicare beneficiaries' inpatient deductible. This change is necessary because of the inappropriate increase in the deductible caused by significant declines in the length of stay experienced since the beginning of PPS.

Capital.—The Commission recommends that beginning in fiscal year 1987 hospital capital payments be phased into PPS. The Federal portion of capital payments should be computed as a fixed percentage add-on to the standardized amounts based on a distinction between fixed and moveable capital. Such a system should be initiated in fiscal year 1987 with respect to moveable equipment. Federal payments for fixed plant and equipment, however, should replace cost reimbursement during a seven- to ten-year transition period.

Incorporating Technological Change.—The Commission recommends annual recalibration of diagnosis-related group (DRG) weights to reflect new technologies and other practice changes that affect the relative use of hospital resources among the DRGs. The Commission's recommendations on individual DRG classification and calculation of payment amounts would modify the current DRG system to incorporate costly new technologies, and respond to special problems like the high costs associated with increased use of sophisticated cardiac pacemakers.

Beneficiary Information.—Concerns and perceptions that PPS is adversely affecting the quality of care Medicare beneficiaries receive prompted the Commission's call for disseminating information to Medicare beneficiaries and providers about PPS and how it functions. Beneficiaries must understand how to utilize the Medicare appeals system to protect their right to appropriate hospital care. The Commission is deeply concerned about reports that DRG-specific average lengths of stay have been inappropriately used as maximum limits on hospital stays.

Quality of Care.—All of the Commission's recommendations regarding the update factor and DRG classifications were formulated with consideration of quality of care. The Commission is particularly concerned, however, about the role that Peer Review Organizations (PROs) play in this vital area. To the extent possible, PRO quality of care review should focus on the entire episode of care, including skilled nursing and home health care. In addition, the Commission recommends that PROs extend their review to selected outpatient surgery cases.

Adjustments to the Payment Formula.—The Commission reiterates its recommendation for prompt action on two PPS payment distribution problems. An adjustment to PPS rates should be implemented for hospitals serving a disproportionate share of low-income patients. Further-

more, the definition of hospital labor market areas should be improved, primarily by identifying additional labor markets within current definitions of urban and rural areas. The Commission is also concerned about the special problems of rural hospitals and the beneficiaries they serve.

AGENDA FOR THE FUTURE

The Commission's future analytic agenda calls for further study in three broad categories: improving the measurement of case mix, improving and updating hospital payment amounts, and assessing the effects of PPS on quality of care. Activities in these categories include the following:

- Improving the measurement of case mix:
  - —Analyses to support incorporation of new and changing technology and practice patterns into the DRG system.
  - —Examination of heterogeneity and case complexity on a DRG-specific basis, broadening the scope to all DRGs.
  - —Research on issues that cut across the measurement of case mix and payment amounts, such as outlier payment policy, and high device costs and the labor/nonlabor portion of the payment amounts.
- Improving and updating hospital payment amounts:
  - —Studies to further refine the discretionary adjustment factor (DAF), to improve the data and methods used to calculate the payment amounts, and to examine issues related to the hospital market basket.
  - —Analyses of issues related to the calculation of payment components, such as the area wage index adjustment.
  - —Evaluations of ProPAC's capital recommendations and the effects of paying for capital through PPS.
- PPS effects on quality of care:
  - —Studies using existing data to identify quality of care problems among targeted patient groups, such as the frail elderly.
  - —Research on hospital discharge planning services to assess how well hospitals link inpatient hospital care with needed post-discharge care.
  - —Assessment of methods to study the entire episode of illness in order to understand the relationship between shortened length of stay, the use of medical services at alternative sites of care, and health care outcomes.

This report appears shortly after publication of ProPAC's report to the Congress, *Medicare Prospective Payment and the American Health Care System,* which documents the impact of PPS during its first year. The two reports convey the Commission's conclusion that PPS is clearly achieving a number of its intended objectives. They also underscore the need for continued assessment of the consequences of PPS and for implementation of measures to improve the system.

REPORT ORGANIZATION

Chapter 1 discusses the Commission's role and the processes it uses to fulfill its mandate; changes in health care financing and public policy that occurred during 1985; and the commissioners' chief concerns. ProPAC's 33 recommendations for improving the prospective payment system are presented in Chapter 2 under three broad categories: improving DRG classification and case-mix measurement; improving and updating the payment amounts; and assessing the effects of PPS on care for beneficiaries. The Commission's proposed analytic agenda is outlined in Chapter 3, which describes areas and issues that ProPAC intends to study in 1987 and beyond.

The Technical Appendixes, a separate volume accompanying the report, contain both descriptive and analytical pieces developed by staff and outside experts that provided the groundwork for the Commission's recommendations.

RECOMMENDATIONS FOR FISCAL YEAR 1987

The Update Factor

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1987, the standardized amounts should be updated by the projected increase in the hospital market basket, adjusted by the following:

- A correction factor for substantial errors previously made in forecasting inflation for fiscal year 1986, and
- A discretionary adjustment factor of minus 0.5 percentage points composed of two allowances:
  - —A minus 1.4 percent allowance for scientific and technological advancement, productivity change, and site-of-care substitution, and
  - —A 0.9 percent allowance for real case-mix change.

In addition, the DRG weights should be adjusted to remove any increase in observed case mix occurring during fiscal year 1986.

This recommendation reflects the Commission's collective judgment of the appropriate change in the level of payment per Medicare discharge under PPS, assuming that the Commission's other concerns regarding the market basket component of the update factor, the DRG weighting factors, and the distribution of payments across PPS hospitals are also addressed. The Commission's recommendation regarding the level of capital payments would also affect per-discharge Medicare payments to hospitals.

Recommendation 2: Allowance for Scientific and Technological Advancement and Productivity Goals, and Site-of-Care Substitution

For the fiscal year 1987 payment rates, the allowance in the discretionary adjustment factor for scientific and technological advancement, productivity improvement, and substitution in the site of service from inpatient to out-of-hospital settings should be set at minus 1.4 percentage points.

Recommendation 3: Allowance for Real Case-Mix Change

Prospective payments should reflect real changes in case mix that are due to changes associated with the characteristics of patients and not changes simply due to better coding of records. The DAF allowance for real case-mix change should reflect both shifts in patients among the DRG categories, as measured by changes in the average case-mix index (DRG case-mix change), and changes in the mix of patients within DRG categories (patient complexity change). For the fiscal year 1987 payment rates, the allowance for real case-mix change should be set at 0.9 percent. This allowance represents a 0.2 percent adjustment for changes in the DRG case-mix index and a 0.7 percent adjustment for patient complexity changes.

Recommendation 4: Update Factor for Excluded Hospitals and Distinct-Part Units

For fiscal year 1987, the target rate of increase limits for the group of psychiatric, rehabilitation and long-term care hospitals and hospital distinct-part units excluded from PPS should be updated to reflect the projected increase in the hospital market basket for these hospitals (corrected for forecast errors) minus a 0.8 percentage point adjustment for productivity and scientific and technological advancement goals established for PPS hospitals.

The target rate of increase limit for children's hospitals and distinct-part units should be updated to reflect the projected increase in the hospital market basket for PPS hospitals (corrected for forecast errors) minus a 0.8 percentage point adjustment for productivity and scientific and technological advancement goals established for PPS hospitals.

Capital

Recommendation 5: Including Capital in the Prospective Payment System

Beginning in fiscal year 1987, the Secretary should initiate a transition to all-inclusive prospec-

tive prices that combine operating and capital cost components in a single prospective payment per case for hospitals.

Recommendation 6: Capital Payment Method

The Federal portion of capital payments should be computed as a fixed percentage add-on to the standardized amounts beginning in fiscal year 1987. The Secretary should immediately develop capital components to be added to the hospital market basket. When appropriate data become available, the components of PPS payments should be recomputed to reflect the addition of capital costs. The results of this recomputation should be implemented as soon as possible, but no later than fiscal year 1988.

Recommendation 7: Level of Federal Capital Payment

Capital payment should be added to the Federal portion of PPS payments for hospital accounting years beginning in fiscal year 1987 at the following levels:

- For building and fixed equipment, projected average Medicare actual capital costs per discharge for fiscal year 1985, trended forward to fiscal year 1987 by an index of construction capital costs.
- For moveable equipment, average actual Medicare capital costs per discharge for hospital accounting years beginning in fiscal year 1983, trended forward to fiscal year 1987 by an index of equipment capital costs.
- The proportion attributed to moveable equipment should be the lesser of the 1983 proportion or 40 percent.

Recommendation 8: Capital Payment Transition

The transition to Federal capital payments under PPS should begin in fiscal year 1987 in accordance with the following provisions:

- There should be no transition for moveable equipment. All payments for moveable equipment should be included as a fixed percentage add-on to the Federal standardized amounts beginning in fiscal year 1987.
- Payments for fixed plant and equipment should be phased in as a fixed percentage add-on to the Federal standardized amounts over a seven to ten year period on a straight-line basis.
- For plant and fixed equipment, hospital-specific capital payment portions should be the actual costs incurred during each year of the transition.
- During the transition, the Federal portion for plant and fixed equipment should be updated each year by an index of construction capital costs.
- The addition of capital to the Federal standardized amounts should reflect base year treatment of return on equity and interest offsets. Return on equity payments should be added to the hospital-specific portion of operating payments. Once the transition to national rates for operating payments ends, there should be no hospital-specific payment for return on equity.

Adjustments to the Payment Formula

Recommendation 9: Disproportionate Share Hospitals

An adjustment to the PPS rates for hospitals serving a disproportionate share of low-income patients should be implemented as soon as possible. This adjustment should specifically incorporate a definition and methodology in keeping with the character of the adjustments already being considered by the Congress. This adjustment should not change the total aggregate dollar amount paid to all hospitals.

Recommendation 10: Improving the Definition of Hospital Labor Market Areas

The Secretary should improve the definition of hospital labor market areas for fiscal year 1987, if possible, and no later than fiscal year 1988. For urban areas, the improved definitions should account for a greater amount of the wage variation between inner-city and suburban hospitals. For rural areas, the improved definitions should account for a greater amount of the wage variation between different rural areas within each state and

between states. The implementation of improved definitions should not result in any change in aggregate hospital payments.

Recommendation 11: Rural Hospitals

In the original PPS legislation of 1983 and the Deficit Reduction Act of 1985, the Congress required the Secretary to study and report on a number of rural hospital issues. To date, none of these studies has been submitted to the Congress. Preliminary studies by the Commission suggest that there are potential problems in the way rural hospitals are treated under PPS. To facilitate open and informed public debate of rural hospital issues, the Commission urges the Secretary to complete and publish the congressionally mandated studies as soon as possible. If the results of the Secretary's studies indicate that changes in payment policies affecting rural hospitals are warranted, appropriate modifications to current policy should be implemented as soon as possible, including legislative change, if necessary. The Commission will continue its analysis of rural hospital issues and make specific recommendations in the future if findings indicate that changes in PPS payment policy are desirable.

The Standardized Amounts

Recommendation 12: Earlier Availability of Medicare Cost Data

The Commission is pleased that the Secretary has taken steps to speed up the availability of Medicare Cost Report data from the first year of PPS. The Commission recommends that making cost data available as soon as possible be an ongoing effort, since these data are vital both to assess the relationship between PPS payments and hospital costs and to analyze the costs of individual DRGs. As part of this ongoing effort, alternative strategies for sampling hospital cost data should be considered. The necessary additional resources should be allocated for timely processing of these data.

Recommendation 13: Recalculating the Standardized Amounts

The standardized amounts used to determine hospital payments under PPS should be recalculated using cost data that reflect hospital behavior under PPS. The results of such a recalculation, with appropriate modifications, could be used in determining the update factor or in rebasing the standardized amounts.

Recalibration

Recommendation 14: Recalibrating the DRG Weights

The DRG weights should be recalibrated annually in order to reflect the use of new technologies and other practice pattern changes affecting the relative use of hospital resources among the DRGs.

Beneficiary Concerns

Recommendation 15: Beneficiary and Provider Information

The Secretary should take immediate action to provide more and better-written information about the Medicare prospective payment system to beneficiaries and providers of care. The Department should work with providers, beneficiaries, and associations of these groups to produce and disseminate this information. Associations of providers and beneficiaries should also increase their own efforts to better educate and inform their members about the Medicare prospective payment system.

Recommendation 16: Notice to Beneficiaries of Rights

Beneficiaries should be made aware of the process of reconsideration and appeal of a hospital denial of coverage for continued inpatient hospital care. Notification should be through a written notice or information bulletin. It should explain beneficiary rights in a clear, helpful, and understandable manner. In addition to a clear statement of rights, the bulletin should inform beneficiaries that they should not accept any oral communication to the effect that they must leave the hospital because their "coverage" has "run out" or because there is a limit on the number of days "allowed" by Medicare for a DRG. The bulletin should be distributed at the time of admission or as soon thereafter as is appropriate based on the

patient's clinical condition. However, additional avenues of distribution should also be developed.

Recommendation 17: PRO Episode of Care Review

The focus of PRO quality of care review should be, to the extent possible, on the entire episode of care. The PRO's review should include, in addition to the period of hospitalization, the quality of care (and outcome) related to the overall episode of illness, including, if appropriate, skilled nursing or home health care.

Recommendation 18: PRO Review of Outpatient Surgery

The Commission is concerned that efforts to shift surgical services from the inpatient to the outpatient setting could have an adverse impact on quality of care for certain Medicare beneficiaries. The PROs should be required to review and monitor the quality of care (and outcome) of outpatient surgery for selected patients and procedures. As a starting point, the PROs should be required to review outpatient surgery cases for those procedures that have been identified for preadmission review, including in particular a sample of those cases for which the PRO has denied payment on preadmission review.

Recommendation 19: Recalculating the Inpatient Hospital Deductible

The Secretary should seek legislative change to the formula for computing the inpatient hospital deductible so that the annual increase in the deductible is more consistent with the annual per-case increase in Medicare payments to hospitals. The proportion of the costs of inpatient hospital care borne by Medicare beneficiaries has inappropriately increased as a result of significant declines in length of stay experienced since the beginning of PPS. This proportion should be lowered to its calendar year 1983 level.

Patient Classification and Case Mix

Recommendation 20: Improving the Measurement of Hospital Case Mix

The Commission believes that the DRG system is currently the most appropriate of the available measures of hospital case mix for the Medicare PPS and should be retained in principle as the system upon which to base Medicare payments to hospitals. Resource use varies considerably, however, within some DRGs. Therefore, the Commission intends to continue its analysis of individual DRGs and to undertake a systematic evaluation of the entire system. The goal is to identify potential problems in DRG construction and classification and to recommend changes that will improve the homogeneity within DRGs and the equity of payments across hospitals.

Recommendation 21: Process for Maintaining and Updating ICD-9-CM

The Secretary should establish a mechanism for maintaining and updating ICD-9-CM diagnosis and procedure codes in a timely and effective manner. This process should include adequate educational support for all users.

Recommendation 22: Process for Interpretation and Assignment of Existing Codes

The Secretary should ensure that interpretation and assignment of existing ICD-9-CM diagnosis and procedure codes for payment purposes strictly adhere to coding rules and guidelines. In order to maintain the integrity and uniformity of the coding system while allowing flexibility for payment purposes, the process for interpretation and assignment of existing ICD-9-CM codes should be assigned to one authorized group.

Recommendation 23: Interim Mechanism for Coding Problems

The Secretary should establish an interim mechanism to allow early identification of new technologies, procedures, and diagnoses and more appropriate DRG assignment when ICD-9-CM codes cannot be updated in a timely manner.

DRG Classification and Weighting Factors

Recommendation 24: Adjustment of the Labor Portion of the Standardized Amounts for Some DRGs Involving Expensive Devices

The labor and nonlabor portions of the standardized amounts should be redefined for DRGs 39, 104, 105, 209, 471, and the newly defined DRGs for pacemaker implantation and replacement (Recommendations 25 and 26), implantable defibrillators (Recommendation 27), and penile prostheses (Recommendation 28). The new portions should more closely reflect the labor-related and nonlabor-related shares of costs for cases in each of these DRGs. These recalculations should be made so that total hospital payments remain unchanged.

The correct labor and nonlabor portions of the standardized amounts should be calculated from data currently being generated in the Health Care Financing Administration's (HCFA) study of the labor portion of costs by DRG. If this information proves to be incomplete, the portions should be calculated from available cost and charge data for these DRGs. The Secretary should study the need for adjustments to the labor and nonlabor portions of the standardized amounts in all DRGs.

Recommendation 25: Reclassification of Pacemaker Cases Based on Type of Device

Prior to recalibration, the DRGs involving implantation of cardiac pacemakers (currently DRGs 115 through 118) should each be restructured into two DRGs, one for cases involving dual-chamber or functionally similar pacemakers, and one for cases receiving other single-chamber pacemakers. New ICD-9-CM procedure codes should be created to distinguish between these types of cases. A mechanism should be established to evaluate the appropriateness of all implants involving dual-chamber or functionally similar pacemakers. In the initial year of this new classification, the weights for all pacemaker DRGs should be calculated using charge data from the PATBILL file and data on cost differences between pacemaker types.

Recommendation 26: Reclassification of Pacemaker Replacement Cases

Prior to recalibration, the cases involving replacement of a permanent cardiac pacemaker, except those with myocardial infarction, congestive heart failure or shock, should be reassigned to DRGs that include only pacemaker replacements.

Recommendation 27: Implantable Defibrillator

Implantable defibrillator cases should be assigned to a unique DRG. The labor and nonlabor portions of the standardized amounts should be redefined for this new DRG to reflect the labor-related and nonlabor-related shares of costs for these cases.

Recommendation 28: Penile Prostheses

Prior to recalibration, cases involving the implantation of a penile prosthesis should be removed from DRG 341 and reassigned to a unique DRG. The labor and nonlabor portions of the standardized amounts should be redefined for this new DRG to reflect the labor-related and nonlabor-related shares of costs for these cases.

Recommendation 29: Additional Payment for Magnetic Resonance Imaging

For a period of three years, Medicare should pay hospitals an additional amount (hereafter termed an add-on) for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a PPS hospital. Under existing capital payment policy, the add-on for fiscal year 1987 should be $124 for each scan performed on beneficiaries in institutions where Medicare pays for the capital costs of an MRI scanner and $282 for each scan performed on beneficiaries in other PPS hospitals. In fiscal year 1988 and fiscal year 1989, the add-on amounts for all hospitals should be recalculated to reflect any change in the average cost of an efficiently produced scan and any changes in capital payment policy.

Recommendation 30: Extracorporeal Shock Wave Lithotripsy

Prior to recalibration, cases in which extracorporeal shock wave lithotripsy (ESWL) is the principal procedure should temporarily be removed from DRG 324 and reassigned to DRG 323. The payments and costs for all cases in this DRG should be monitored to determine the appropriateness of PPS payments for operating costs. A unique procedure code should be identified for ESWL.

Recommendation 31: Lymphomas and Leukemias

Prior to recalibration, cases currently assigned to DRGs involving lymphoma, leukemia, and other related diagnoses (DRGs 400-404) should be reclassified into one of five newly defined DRGs. The new classification should provide a unique DRG for acute leukemia cases not involving a major operative procedure, eliminate age as a criterion for DRG assignment, and modify present classification based on operative procedure, complications and comorbidity. Other ways of further improving these DRGs should continue to be explored.

Recommendation 32: Upper Extremity Procedures

Prior to recalibration, cases involving procedures of the upper extremity that are currently classified in DRGs 223, 224, 228, and 229 should be reassigned based on anatomical location and the presence of systemic collagen vascular disease or implantation of joint prostheses or complications and/or comorbidities. Nonsurgical hip fracture cases currently being assigned to DRGs 223, 224, 225, 228, and 229 should be reassigned to the appropriate medical DRG.

Data Development and Research

Recommendation 33: Maintaining a Commitment to Data Development and Research on PPS

The Secretary should continue to devote substantial resources to data development and research for monitoring and improving PPS and understanding its effects on the health care system. Studies mandated by the Congress that are already due should be completed and made public as soon as possible, and new studies that analyze more recent data should be designed and implemented as soon as possible. While ProPAC and other organizations will participate in this process, the major commitment to PPS data development and research must reside in the Department of Health and Human Services.

Chapter 1

Introduction and Commission Priorities

The Medicare prospective payment system (PPS) for payment of inpatient hospital services was enacted by the Social Security Amendments of 1983 (Pub. L. 98-21). In the same legislation, the Congress created the Prospective Payment Assessment Commission (ProPAC) to advise the executive and legislative branches on maintaining and updating PPS.

This report to the Secretary of the Department of Health and Human Services (HHS) contains the Commission's recommendations for updating and modifying Medicare's prospective payment system for inpatient hospital care. This chapter describes the Commission's role and responsibilities. It also summarizes major policy changes and issues in health care financing during the past year. Finally, it describes the priorities ProPAC has established to govern its functions and decision making. Chapter 2 contains the Commission's recommendations; Chapter 3 describes analyses and studies ProPAC has under way or plans for the future.

THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION: ITS ROLE, RESPONSIBILITIES, AND PROCESSES

The Congress established ProPAC as a permanent, independent commission with responsibilities related to maintaining and updating the new payment system. The 15 Commission members are appointed by the director of the Office of Technology Assessment (OTA), the Congress of the United States. Members are selected, as required by the law, to provide independent expertise in health care delivery, financing, and research. (Biographies of current Commission members appear in this report's appendix.)

Commission Role and Responsibilities

The role of the Commission is to function as a highly knowledgeable, independent panel that provides analysis of and advice on PPS to the executive and legislative branches of the Federal government. This report fulfills the Commission's two primary responsibilities mandated by Pub. L. 98-21. These are to:

- Recommend annually to the Secretary of the Department of Health and Human Services the appropriate percentage change in the Medicare payments for inpatient hospital care, called the "update factor," which is applied to the previous year's payment rates.
- Consult with and recommend to the Secretary of the Department of Health and Human Services necessary changes in diagnosis-related groups (DRGs), including advice about establishing new DRGs, modifying existing DRGs, and changing the relative weights of the DRGs.

Besides the report and recommendations submitted in April to the Secretary for consideration in rulemaking, each fall the Commission reports to the Congress its evaluations of adjustments made by the Secretary. ProPAC also reports to the Congress annually about the overall effects of PPS on American health care delivery and financing, and provides other reports and analyses to the Congress as requested.

Commission Processes

The Commission has established a subcommittee structure to facilitate its work. ProPAC holds open meetings and solicits comment and involvement from groups or people with information relevant to its responsibilities. To enhance the Commission's communications with the public, all meetings are announced in the *Federal Register*. ProPAC maintains a mailing list and schedules public comment periods at each open Commis-

sion and subcommittee meeting. Formal notice has been published in the *Federal Register* (50 Fed. Reg. 1657 [1985]) describing the process for interested parties to use in submitting information to the Commission. The Commission also has adopted a general policy statement. This statement, along with information about the subcommittee structure and Commission meeting dates, is published in this report's appendix.

The Commission requested and received, through the congressional appropriations process, a budget of $3.2 million to carry out its work in fiscal year 1985; a slight increase to approximately $3.3 million was approved for fiscal year 1986. These funds support the administrative, research, and analytic work of the Commission and an executive director and staff of no more than 25.

This report does not explain the background or operation of the prospective payment system. Rather, the Commission assumes that the reader has a general understanding of PPS. Historical perspectives on PPS and a full description of the system are found in the Commission's *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1985* and the report's *Technical Appendixes*. The 1985 report is available through the Government Printing Office, Superintendent of Documents.

CHANGES IN HEALTH FINANCING AND PUBLIC POLICY SINCE APRIL 1985

In the past year, the Federal policy debate has been dominated by the subject of reduction of the large national deficit. Because the Medicare program represents such a significant proportion of Federal spending (an estimated $74 billion in fiscal year 1986), the course of the debate is critical to those concerned about health financing policy, and the Commission monitored it closely. The debate culminated with the enactment in December 1985 of the Gramm-Rudman-Hollings Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. 98-177.

Congressional actions to reduce the deficit and to make other policy-related Medicare and PPS changes were similarly monitored. At the time the Commission adopted the recommendations contained in this report, 1986 Medicare PPS regulations had not been implemented due to congressionally mandated postponement.

While the Commission understands the reasons for the delay, it regrets that several major operational changes recommended by ProPAC and adopted by the Secretary in regulations were not implemented. The Commission is especially concerned about delays in the PPS recalibration process, which is designed to ensure that the system operates with DRG weights that represent the most current data base reflecting recent changes in medical practice patterns and technology.

Other policy concerns that surfaced during this time are of equal and continuing concern to the Commission. Many are addressed in ProPAC's recommendations and future priorities for work (see Chapters 2 and 3). Of particular importance to the Commission were congresssional hearings and media reports indicating that PPS might have adversely affected the quality of care that Medicare beneficiaries receive. While this subject is discussed elsewhere in this report, the Commission reiterates its commitment to continuing careful and thoughtful monitoring of this area.

There are serious methodological difficulties in measuring quality of care, and the definition of high-quality medical care may vary among individuals. The Commission believes, however, that there is a strong *perception* among some beneficiaries, physicians, and other providers that quality of care has already deteriorated under PPS or may deteriorate in the future. ProPAC will work to ensure that adequate systems are developed and implemented to monitor quality of care under PPS so that high-quality care will continue to be available to Medicare beneficiaries.

PRIORITIES AND CONCERNS OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

In its April 1985 report, the Commission set forth a list of cross-cutting priorities to guide all of its analysis and decision making. These priorities have again served to form the underlying basis of ProPAC's work. They are to:

- Maintain access to high-quality health care,
- Encourage hospital productivity and long-term cost-effectiveness,
- Facilitate innovation and appropriate technological change,
- Maintain stability for providers, consumers, and other payers, and
- Base decisions on reliable, timely data and information.

Maintaining Access to High-Quality Health Care

The Commission's paramount concern with the maintenance of quality of care has been expressed. With its altered financial incentives for hospitals, PPS has created the challenge of maintaining quality health care while restraining health care costs. Hospitals that are paid a fixed amount per type of case by Medicare and other payers (who adopt PPS or use other competitive strategies like preferred provider organizations) can no longer be indifferent to the resources expended in patient care. PPS encourages a reduction of hospital inputs—tests, special procedures, supplies, equipment, personnel time, and hospital days—because hospitals can lower their costs only by controlling resources devoted to inpatient stays. Clearly, as the increase in hospital spending is slowed and cost savings are realized, the need to develop methods to detect adverse effects on quality and access is intensified.

The Commission strongly perceives its role as supporting the establishment of payment rates that will enable hospitals to continue to deliver high-quality health care. The DRG classifications and weights must be modified appropriately to reflect changes in medical practice. Similarly, the update factor must be adequate to enable hospitals to expend the resources required to maintain the appropriate amount and type of care.

As it is reflected in this report, the Commission has begun active examination of quality issues. ProPAC's work in this area will continue and will intensify in the future.

Encouraging Hospital Productivity and Long-Term Cost-Effectiveness

The Commission's concern for maintaining quality under PPS is accompanied by a parallel concern for promoting productivity and long-term cost-effectiveness of the health care system.

PPS uses the diagnosis-related groups to classify patients and define the hospital product. Hospital care is only one of many "products" that contribute to improvement in health status. Other modes of care outside of the hospital also contribute to improved health. Thus, the Commission will look beyond the hospital setting to assess and measure productivity in the context of PPS.

PPS provides incentives for improving productivity and cost-effectiveness of services. PPS also creates incentives to move services to other settings. If these services can be provided at lower cost and equal quality in other settings, such a move should be encouraged. Adjustments need to be made in hospital payments to reflect the movement of services to alternative sites, however, to avoid paying for services twice—once in the hospital DRG payment and again in payment for substitute services.

ProPAC is also concerned that the emphasis on reducing costs may deter the adoption of new services and technologies that may initially increase costs, even though in the long-run they may improve patient care, productivity, and cost-effectiveness. The Commission's work will continue to carefully assess this potential problem.

Facilitating Innovation and Appropriate Technological Change

The Commission believes the Medicare prospective payment system should have an unbiased effect on technological advancement. PPS payment levels should not inhibit the development or diffusion of new technologies and practices, nor should payment levels result in their inappropriate adoption. Instead, technology and practices should be examined in light of both long- and short-term potential effects on quality and productivity.

In reviewing the potential effects of PPS on the adoption of new technologies and practices, the Commission must consider whether payment policies and amounts are sufficient to enable hospitals to adopt them. ProPAC has addressed these concerns by examining a series of options for adjustments to PPS that could help foster the appropriate adoption of new technologies. Continued analysis of these types of problems is a high priority for the Commission. One approach is to adjust the current DRG weights to reflect changes in technology and practice patterns. In addition, the Commission has considered—and will continue to explicitly consider—scientific and technological advances as part of recommendations related to the update factor.

Maintaining Stability for Providers, Consumers, and Other Payers

The Commission believes that in an environment where health care delivery and financing are changing rapidly, its recommendations should provide as much predictability and stability as possible. During its deliberations, the Commission has identified many problems which are described throughout this report. Equitable and workable solutions are much more difficult to develop. The Commission has made only those recommendations it considers most important and amenable to well-informed decision making.

The Commission's philosophy in decision making has been to act where there is immediate need for change and to allow the new PPS to become fully mature and operational—and stable—before suggesting new approaches or significant alterations.

Decision Making Based on Reliable, Timely Data and Information

The Commission's major contribution to the maintenance and evolution of the maturing PPS is the development of recommendations grounded in quantitative data and analytic reasoning, tempered by judgment and experience. The availability and use of accurate, timely data and information, analyzed and presented without bias as a basis for decision making, are critical priorities of the Commission and its staff. The Commission will continue to strive to fulfill a role in which its approach is always to inform itself with the best and most timely information available before making recommendations.

Chapter 2

Recommendations

The Commission's recommendations for fiscal year 1987 are the result of a process of agenda-setting, information collection, analysis, and deliberation continuing from publication of the April 1985 report to the Secretary. ProPAC selects issues for consideration to conform with its statutory mission and to contribute to an open policy debate on matters of substantial importance to beneficiaries, hospitals, and the Medicare program. The Commission's recommendations, with the analysis and reasoning that accompany them, are intended to inform the policy debate that will result in both regulatory and statutory changes in PPS.

The recommendations reflect the collective judgment of the full Commission. In some cases, however, individual commissioners did not always agree with the majority opinion.

Some recommendations, such as those that pertain to the annual update of payment rates, will be repeated in similar format every year. Others, such as the definition of hospital labor market areas, are elaborations or extensions of recommendations that ProPAC developed before this year. Finally, several issues are addressed in the Commission's recommendations for the first time.

Recommendations made previously, but not yet implemented by the Secretary, are still in effect. For example, the Commission considers it important for the Secretary to implement the 1985 recommendations concerning the hospital market basket, even though there are no additional recommendations on this topic this year.

Concern for reducing the Federal deficit and attaining a balanced budget were dominant public policy issues during the period in which these recommendations were developed. It is the role of the Congress rather than the Commission, however, to determine the extent to which Medicare payments should be reduced in light of the Federal deficit. While ProPAC did not explicitly take these budgetary concerns into account, the recommendations were developed in recognition of a very constrained fiscal environment. Furthermore, the Commission believes that budgetary pressures intensify the need to address technical issues related to the updating and distribution of payments that may bear on the quality of care furnished to Medicare beneficiaries.

The following discussion presents an overview of the Commission's 33 recommendations for fiscal year 1987, which are discussed in detail later in the chapter. Background information, statistical analyses, and alternative options are in the Technical Appendixes. The issue areas addressed by the Commission are:

- The update factor,
- Capital,
- Adjustments to the payment formula,
- Standardized amounts,
- Recalibration,
- Beneficiary concerns,
- Patient classification and case mix,
- DRG classification and weighting factors, and
- Data development and research.

OVERVIEW OF THE COMMISSION'S RECOMMENDATIONS FOR FISCAL YEAR 1987

The Update Factor

The PPS statute requires the Commission to:

> . . . take into account changes in the hospital market basket . . ., hospital productivity, technological and scientific advances, the quality of care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient services,

in making its recommendations on the update factor. The Commission is required to report its recommendations on the update factor to the Secretary of Health and Human Services no later than April 1 of each year, and

> . . . taking into consideration the recommendations of the Commission, the Secretary shall determine . . . the percentage change . . . which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

Recommendation 1 reflects the Commission's overall judgment of the appropriate change in the level of payment per Medicare discharge in PPS hospitals for fiscal year 1987. The Commission believes its responsibility under the statute is to be as specific as possible in making its recommendation on the update factor. Therefore, the Commission has provided an interim estimate of the recommended update. Because several of the components of the update factor will probably change as a result of the receipt of new data before publication of the final rules for fiscal year 1987, the Commission's overall numerical recommendation is likely to be modified. The Commission will publicize its revised recommendation on the update factor during the rulemaking process.

Recommendations 2 and 3 cover the discretionary components of the update factor, which reflect considerations other than inflation in the market basket of hospital input prices. Recommendation 2 consists of a combined allowance for scientific and technological advancement and productivity goals and for changes in the site of services delivered to Medicare hospital inpatients. Recommendation 3 is an allowance for changes in patient mix and complexity that are not otherwise provided for in the PPS payment structure. Recommendation 4 satisfies the Commission's statutory obligation to recommend an update factor for hospitals and distinct-part units of hospitals excluded from PPS.

Capital

When the Commission established its agenda for the April 1986 report, it decided to examine PPS capital payment issues, expecting that the Administration's congressionally mandated capital payment report and proposal would have been published by early 1986 at the latest. In the fall of 1985, ProPAC began its work on capital by reviewing issues and developing principles for evaluation of capital payment proposals advanced by the Administration and others. In late 1985, it became evident that the Administration planned to address capital payment under PPS through regulation, without early publication of a detailed plan and analysis of options. The Commission then decided to develop recommendations related to components of a system for paying for capital under PPS without committing itself to the construction of a complete proposal for capital payment.

Early in its deliberations on capital payment, the Commission developed principles to guide the development of its recommendations. The principles regarded as most important are that the capital payment system should:

- Provide neutrality between capital and operating cost trade-offs,
- Reflect capital intensity variations across the DRGs, and
- Contribute to controlling aggregate expenditures and the level of capital growth.

These principles, which are more fully described in Technical Appendix A, are reflected in the Commission's recommendations on capital payment.

Recommendations 5 through 8 address the following capital payment components:

- The inclusion of capital in an all-inclusive price,
- The method for incorporating a capital component into PPS payments,
- The level at which capital payment is brought into PPS, and
- The transition from individual hospital capital payments to a fully implemented prospective system.

Although the capital payment recommendations do not constitute a comprehensive proposal, and other decisions are necessary before implementation, the Commission thinks its recommendations are a solid foundation for a fair and efficient system. As the discussions accompanying Recommendations 5 through 8 and in Chapter 3 indicate, the Commission will continue to address technical and policy issues concerning capital payment after publication of this report. It will also carefully review the detailed proposal that will be published by the Administration in its proposed regulations covering PPS changes for fiscal year 1987.

As of this writing, hospitals are scheduled to be paid fully national rates for operating payments beginning in fiscal year 1987. Action on the fiscal 1986 reconciliation bill or other legislation may extend the transition for operating payments, however. If a delay is enacted, the Commission will consider implications for implementation of capital payment under PPS and whether the capital payment transition should be coordinated with the operating payment transition.

The Commission's recommendations should not be construed as an endorsement of the Secretary's intention to implement capital payment under PPS by regulation rather than by seeking statutory change. The PPS statute requires the Commission to make all of its April report recommendations to the Secretary. Legislative proposals for capital payment already have been introduced in the Congress, and further proposals and modifications are likely. ProPAC will continue to share its data and analyses on this issue with legislative offices that are examining alternative capital payment strategies.

Adjustments to the Payment Formula

The Commission believes that the ways in which the PPS payment formula distributes payments to hospitals are extremely important both to Medicare beneficiaries and to interhospital equity. Payments that are adequate, on average, may be insufficient for certain types of hospitals and the beneficiaries who depend on these hospitals. Recommendations 9 through 11 address the distributional consequences of the PPS payment formula.

Recommendations 9 and 10 concern issues that were addressed in the 1985 April report. In Recommendation 9, the Commission reaffirms its conviction that hospitals serving a disproportionate share of low-income patients should receive an allowance under PPS to cover the added Medicare costs associated with their care. ProPAC supports the way the Congress approached this problem during the 1985 reconciliation process. It believes, however, that a reiteration of the recommendation is called for because no payment adjustment had been implemented by the time this report was written. In Recommendation 10, the Commission expands its 1985 recommendation on the definition of hospital labor market areas. This year, based on information it has collected, ProPAC recommends more detailed changes and will be even more specific during the rulemaking period.

In Recommendation 11, the Commission addresses issues related to the treatment of rural hospitals under PPS. The Commission is concerned that PPS may unduly place these hospitals and the beneficiaries they serve at a disadvantage. More information needs to be collected, however, before determining whether specific changes in the payment system are necessary. ProPAC's concerns include both individual components of the payment system and broad issues, such as the appropriateness of perpetuating differences in payment rates based on the historically lower costs of rural hospitals and, more generally, the appropriateness of the payment system for hospitals that tend to be small and isolated.

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The Standardized Amounts

In the April 1985 report, the Commission recommended recalculating the standardized amounts with cost data reflecting hospital experience under PPS. This year, ProPAC expands its position on the standardized amounts in Recommendations 12 and 13. It is important to have cost data available as soon as possible after the end of hospital accounting years, and in Recommendation 12 the Commission urges exploration of alternative strategies to ensure early availability of such data. In Recommendation 13, the Commission again recommends recalculation of the standardized amounts with more current data. The results of the recalculation might be used to rebase the standardized amounts or to help determine the update factor for the upcoming year.

Recalibration

In Recommendation 14, the Commission states its belief that the DRG weights should be recalibrated annually. The accompanying discussion presents recommended steps in the recalibration process and further adjustment of the weights to remove observed changes in the DRG case-mix index. Even though the PPS statute requires recalibration only every four years, the benefits of annual recalibration far outweigh the associated administrative costs. Annual recalibration is especially desirable in view of evidence of rapidly changing patterns of medical practice in recent years.

Beneficiary Concerns

Chapter 1 cited quality of care under PPS as a paramount concern of the Commission since its inception. In Recommendations 15 through 18, the Commission notes ways in which quality of care can be maintained or improved under PPS. These recommendations do not cover the full range of ProPAC's concerns about quality, however. The Commission will continue to address quality in its analytic agenda and in future recommendations.

In Recommendations 15 and 16, the Commission responds to evidence of misinformation that, if not corrected, may be detrimental to Medicare beneficiaries. The Commission believes that both beneficiaries and providers need to be better informed about PPS. Existing misperceptions, particularly about length of stay limits imposed by PPS, should be dispelled immediately. In addition, beneficiaries should be systematically informed of their rights when hospitalized, including the process for appealing hospital denial of continued inpatient services.

In Recommendations 17 and 18, the Commission focuses on expanding the review activities of Peer Review Organizations (PROs) to include a broader range of quality-of-care considerations than those limited to the inpatient stay. The Commission believes that the PROs should examine the entire episode of care, which includes, but is not always limited to, an inpatient stay. Further, when PROs determine that inpatient surgical services are unnecessary, they should be required to monitor quality of care when surgery is performed on an outpatient basis. Both recommendations derive from a concern that changes in medical practice patterns partially attributable to PPS incentives may be accompanied by deterioration in quality of care if the effects of these changes are not monitored.

The Commission's concern for beneficiary welfare under PPS is not confined to quality of care issues. In Recommendation 19, the Commission notes that the inpatient hospital deductible has inappropriately risen partly because of declining length of stay under PPS. It recommends that the formula for setting the deductible be changed to be more consistent with the per-case orientation of PPS. The deductible should be reduced to the same proportion of the cost of an inpatient stay as was in effect before PPS implementation. Although this reduction would increase government outlays, it was never intended that PPS would increase the proportion of Medicare expenditures borne by beneficiaries.

Patient Classification and Case Mix

The April 1985 report identified several potential problems with the use of DRGs for prospective payment. In Recommendations 20 through 23, the Commission addresses some of these problems and states its intention to continue to explore ways to improve the DRGs for payment pur-

poses. The current DRG system should be retained for the time being, with improvements effected through incremental change. As stated in Recommendation 20, however, the Commission will systematically evaluate the DRG system. The Commission also calls for improvements, in Recommendations 21 through 23, in the International Classification of Diseases (ICD- 9-CM) coding system and the ways in which its codes are adapted for use in PPS.

DRG Classifications and Weighting Factors

The PPS statute requires the Commission to:

> . . . consult with and make recommendations to the Secretary with respect to the need for adjustments [in classifications and weighting factors] . . . based on its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities.

These adjustments refer to the system for:

> . . . classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

They also relate to the assignment of:

> . . . an appropriate weighting factor [to each diagnosis-related group] which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

To the extent possible, the Commission attempts to develop generic solutions to DRG classification and weighting problems so that its decisions will apply to several DRGs. In Recommendation 24, for example, the Commission addresses the general problem of pricing DRGs that include cases using expensive devices. Changes in the treatment of several specific DRGs are recommended, and the methodology the Commission proposes might also be applied to other DRGs.

Recommendations 25 through 32 concern DRG classification, weighting, and pricing issues covering a broad range of medical technologies and procedures:

- DRG classification of pacemaker cases (Recommendations 25 and 26),
- DRG classification and weighting for cases involving implantable defibrillators and penile prostheses (Recommendations 27 and 28),
- Supplementary payment for cases involving magnetic resonance imaging (Recommendation 29), and
- DRG classification and weighting for cases involving extracorporeal shock wave lithotripsy, lymphomas and leukemias, and upper extremity procedures (Recommendations 30 through 32).

The Commission realizes that its recommendations in these areas, if implemented, would add DRGs and increase the complexity of the PPS system. Nevertheless, ProPAC is convinced that these changes would improve payment equity and reduce hospital reluctance to adopt quality-enhancing new technologies. The benefits of these changes to beneficiaries would far outweigh any corresponding increases in administrative costs.

Data Development and Research

In Recommendation 33, the Commission expresses its belief that PPS requires extensive analysis with more recent data in order to understand its consequences for hospitals and beneficiaries and to effect improvements. Most of the analysis of PPS done by HHS and the Commission has utilized data that reflect only a relatively brief period of hospital payment under PPS. The Commission therefore recommends that HHS should continue to devote substantial resources to the PPS data development and research effort. The Commission's own plans for data development and research on PPS issues are described in Chapter 3.

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RECOMMENDATIONS FOR FISCAL YEAR 1987

The Update Factor

Recommendation 1: Amount of the Update Factor for PPS Hospitals

For fiscal year 1987, the standardized amounts should be updated by the projected increase in the hospital market basket, adjusted by the following:

- **A correction factor for substantial errors previously made in forecasting inflation for fiscal year 1986, and**
- **A discretionary adjustment factor of minus 0.5 percentage points composed of two allowances:**
  - **—A minus 1.4 percent allowance for scientific and technological advancement, productivity change, and site-of-care substitution, and**
  - **—A 0.9 percent allowance for real case-mix change.**

In addition, the DRG weights should be adjusted to remove any increase in observed case mix occurring during fiscal year 1986.

This recommendation reflects the Commission's collective judgment of the appropriate change in the level of payment per Medicare discharge under PPS, assuming that the Commission's other concerns regarding the market basket component of the update factor, the DRG weighting factors, and the distribution of payments across PPS hospitals are also addressed. The Commission's recommendation regarding the level of capital payments would also affect per-discharge Medicare payments to hospitals.

The Commission's current estimate is that this recommendation is likely to lead to a 2.8 percent increase in the per-case PPS payment amounts for fiscal year 1987. The estimate includes the adjustment to the DRG weights for all observed changes in the DRG case-mix index. The numerical amount of the Commission's update factor recommendation will probably change in coming months as more recent market basket forecasts and more information regarding changes in hospital case mix become available. The table below summarizes the components of the Commission's update factor recommendation.

The update factor should be applied to the standardized amounts as they exist at the end of

Estimated Increase In PPS Payment Amounts For Fiscal Year 1987 Under Commission Recommendations

Fiscal Year 1987 Market Basket Increase		4.6%[a]
Correction For Market Basket Forecast Errors In Fiscal Year 1986		−0.3[b]
Discretionary Adjustment Factor		−0.5
Scientific And Technological Advancement	0.7[c]	
Productivity	−1.5	
Site Substitution	−0.6	
Real Case-Mix Change In Fiscal Year 1986	0.9	
DRG Case-Mix Index	0.2[d]	
Within-DRG Patient Complexity	0.7[e]	
Subtotal (Update In Standardized Amounts)		3.8
Observed Change In Case-Mix Index (Adjustment Made To DRG Weights After Recalibration)		−1.0[d]
Total Change In DRG Prices		2.8[f]

[a] Data Resources Inc. (DRI) forecasts based on actuals through calendar year 1985. This estimate takes into account the Commission's April 1985 recommendation for changing the treatment of wages in the hospital market basket. The DRI forecast for the current HCFA market basket is 4.4 percent.

[b] ProPAC estimate comparing DRI forecasts based on actuals through calendar year 1984 to forecasts based on actuals through the third quarter of 1985. The estimated adjustment here excludes errors in forecasting internal price proxies, as recommended by the Commission in its April 1985 report.

[c] In addition to this allowance, the Commission's recommended add-on for Magnetic Resonance Imaging scans would increase payments to hospitals. If capital is added to PPS in fiscal year 1987 at a level lower than projected under current law, this component should be higher.

[d] For this report, the Commission has incorporated a one percent reduction in the DRG weights to account for observed changes in the DRG case-mix index during fiscal year 1986, although this figure may change as more recent data are reported. Based on historical trends, we estimate that the portion of this increase due to real changes in DRG case mix is 0.2 percentage points.

[e] Estimate based on data from the Commission on Professional and Hospital Activities through 1984. The estimate may change once 1985 data become available.

[f] As recommended by the Commission, the addition of capital would increase PPS payment amounts. Compared to the current law projection, however, ProPAC estimates that its capital recommendation would reduce capital payments by 10 percent in fiscal year 1987 and about 22 percent over the next five years.

fiscal year 1986. The final level of the 1986 amounts depends on the outcome of the budget reconciliation legislation, which would increase the amounts by 0.5 percent, and the Supreme Court ruling on the constitutionality of the Gramm-Rudman-Hollings deficit-reduction act, which lowered payments to hospitals by 1 percent beginning in March 1986. The actual increase in per-case payments to hospitals may be higher than the update factor if the overall DRG case-mix index increases during fiscal year 1987.

The Commission's recommendation for fiscal year 1986 would have increased payment amounts by 1.5 percent. ProPAC does not believe, however, that the difference between that recommendation and the actual amounts hospitals received is significant enough to take directly into account in determining the fiscal year 1987 update factor. Payments to hospitals may have been higher than reflected in the update factor due to changes in the DRG case-mix index. Moreover, analysis by the Commission and others indicates that the Federal portions of the original PPS rates were higher than intended.

Furthermore, overall the hospital industry appears to be financially healthy. Medicare's policy of continued cost reimbursement for capital has contributed to this financial health. Because of these factors, the Commission believes that applying its recommended update factor for fiscal year 1987 to the actual fiscal year 1986 amounts would be appropriate. This update would provide an aggregate payment level adequate to ensure the provision of accessible, cost-effective, quality inpatient hospital care to Medicare beneficiaries. If, however, future updates received by hospitals are substantially different from recommended levels, the Commission will consider these differences in developing its update factor recommendations.

ProPAC believes that the principle of correcting for the previous year's market basket forecast errors should be applied in determining the update factor each year. It can be argued, however, that hospitals should not have rates adjusted downward in fiscal year 1987 because there was no increase in the payment amounts in fiscal year 1986. On the other hand, the market basket forecast was used by the Secretary in developing fiscal year 1986 recommendations, although the market basket increase was offset by other factors.

In the current environment of fiscal stringency, an estimated 2.8 percent increase in PPS payment amounts for fiscal year 1987 may seem unduly high. Hospitals received no increase for the first half of fiscal year 1986, and may receive a net reduction for the second half of the year if the Gramm-Rudman-Hollings deficit-reduction act is upheld. The President's proposed budget for fiscal year 1987 estimates a 2.0 percent increase in PPS payment rates. The Commission's recommended increase is very stringent compared to historical trends in Medicare payments to hospitals, however. Between 1972 and 1983, these payments averaged about 3 percentage points *above* inflation, whereas the Commission estimates its recommendation for fiscal year 1987 to be 1.5 percentage points *below* inflation.

In its April 1985 report, the Commission made a number of recommendations for change in the hospital market basket. It is pleased that the Health Care Financing Administration has these recommendations under study, and hopes that appropriate changes are made for the fiscal year 1987 update factor. In particular, the Commission believes that wages should be treated differently in the market basket. In addition, the forecast error correction should be applied only to substantial errors in the external price change measures, and the market basket weights should be rebased. Other components of the update recommendation are addressed in more detail in the discussions accompanying Recommendations 2 and 3. Adjusting the weights to remove all observed case-mix change is discussed in Recommendation 14.

Other recommendations would also affect Medicare payments to hospitals. Recommendations 5 through 8 address the inclusion of capital payments in PPS. The addition of capital would increase per-case PPS payment amounts. But because the level at which the Commission recommends the addition of capital payments is lower than that forecasted for fiscal year 1987 under the current pass-through, the recommendation represents an estimated 10 percent reduction in per-case capital payments to hospitals from the cur-

rent law projection. Over five years, the reduction would be about 22 percent compared to a continuation of cost pass-through payment for capital. This reduction would represent less than 3 percent of total Medicare payments to hospitals during the five-year period.

Recommendation 29 would implement additional payments to hospitals for patients receiving a magnetic resonance imaging scan (MRI). This add-on would have a limited financial effect in the first year of implementation. Under the Commission's approach, all such increases in payment would be offset by reductions in the scientific and technological advancement component of the discretionary adjustment factor.

Recommendation 2: Allowance for Scientific and Technological Advancement and Productivity Goals, and Site-of-Care Substitution

For the fiscal year 1987 payment rates, the allowance in the discretionary adjustment factor for scientific and technological advancement, productivity improvement, and substitution in the site of service from inpatient to out-of-hospital settings should be set at minus 1.4 percentage points.

The Commission's update factor is composed of two overall elements—the hospital market basket inflation factor and the discretionary adjustment factor. The discretionary adjustment factor (DAF) is the quantitative expression of the Commission's judgment regarding the rate at which the Medicare standardized amounts should increase or decrease beyond inflation in the hospital market basket. This judgment reflects considerations outlined in the statute as well as other factors that ProPAC determines are important.

The Commission believes that its recommendation for the DAF results in an update factor which represents the smallest rate of increase that is consistent with maintaining high-quality services and sufficient access to hospital care for Medicare beneficiaries. While the Commission's recommendations do not explicitly take into account budgetary considerations related to the Medicare Hospital Insurance Trust Fund's solvency or the Federal deficit, they were developed in recognition of a very constrained fiscal environment.

The Commission recognizes that actions to reduce the Federal deficit could have a significant effect on the fiscal year 1987 update factor. Nevertheless, the Commission believes that the DAF should reflect its best judgment about the amount necessary to provide efficient, effective hospital inpatient services after accounting for inflation.

In constructing the DAF, the Commission is concerned with identifying factors that produce a change in the average cost of a discharge and determining the effect of these changes on the standardized amounts. The Commission recognizes that many factors can affect the average cost per case, and that it is difficult to develop precise estimates for the effect of individual factors. Because these factors are so closely related, available data frequently reflect more than one DAF component. For example, length-of-stay reductions reflect hospital productivity changes as well as shifts of services from inpatient to out-of-hospital settings.

Nevertheless, the Commission has attempted to allocate its fiscal year 1987 estimate of the overall discretionary adjustment factor to the following four components considered in its development: (1) scientific and technological advancement, (2) hospital productivity change, (3) site-of-care substitution, and (4) real case-mix change. A numeric allowance was developed for each component, after consideration of the interrelationships among the components. These allowances represent broad guidelines; they do not imply a high degree of precision or specificity in the estimation of the individual components.

DAF component	*Percentage allowance*
Scientific and Technological Advancement	+0.7
Hospital Productivity	−1.5
Site-of-Care Substitution	−0.6
Net Adjustment (Before Inclusion of the Allowance for Real Case-Mix Change)	−1.4
Real Case-Mix Change (Recommendation 3)	+0.9
DAF Total	−0.5

In total, the Commission recommends that the fiscal year 1987 update factor include a 0.5 per-

cent reduction to accommodate the considerations outlined in the DAF recommendation, compared to a 0.2 percent reduction recommended for fiscal year 1986. The numeric value of the Commission's DAF recommendation is subject to change in the next few months as more recent information on hospital case-mix change becomes available.

The Commission began the development of an overall DAF recommendation by examining trends in net intensity per admission. Net intensity is a measure of hospital expenditure changes after taking inflation into account. Changes in net intensity per admission reflect changes in productivity, case mix, and patterns of practice as well as errors in the measurement of input prices and time lags between input price increases and expenditure increases. Measures of net intensity also reflect increases in capital expenses that are currently not included in the standardized amounts.

Net intensity per case grew 3.9 percent during the first eight months of 1985—a rate of growth that is consistent with the pre-PPS long-term trend of double the real growth in the general economy. The Commission continues to believe that future growth in hospital expenditures should be constrained to reflect a balance between long-term growth in the hospital industry and in the rest of the economy.

The continued intensity growth in the hospital industry, however, masks some important changes under PPS. Measures of intensity are highly volatile and sensitive to short-term shifts in volume. The recent increase in net intensity per case can be largely attributed to decreases in admissions rather than to increases in hospital expenses. While net intensity per case increased 3.9 percent in the first eight months of 1985 compared to 1.7 percent in 1984, hospital admissions decreased 6 percent. Total inpatient expenses adjusted for inflation decreased in 1985. This suggests that reductions in net intensity are achievable as the hospitals adjust their use of resources to a lower volume of admissions.

Based on these overall considerations, the Commission has recommended a small negative aggregate allowance for the DAF. The remainder of this discussion addresses the first three components of the DAF recommendation for fiscal year 1987. The fiscal year 1987 adjustment for real case-mix change is addressed in Recommendation 3 and its accompanying discussion.

Scientific and Technological Advancement.—The scientific and technological advancement allowance is a future-oriented policy target. It reflects the Commission's judgment of the financial requirements for hospitals to implement quality-enhancing, cost-effective, but cost-increasing health care technologies and practices. This allowance reflects the judgment that the hospital industry will not and should not experience the same rate of growth as in the past decade. Nevertheless, a sufficient allowance must be provided to allow the industry to keep pace.

The Commission believes that advances resulting in greater efficiency for the hospital do not require a special allowance since they should ultimately be reflected in lower costs. The Commission also believes that scientific and technological innovations that neither improve quality or effectiveness nor lower costs are not relevant for consideration under the DAF since these innovations do not represent any real advancement. Those that contribute to changing the effectiveness and quality of hospital services may or may not contribute to increasing the cost of care.

This allowance represents the Commission's judgment about the funds required to cover increased hospital operating expenses related to the addition of both low- and high-cost quality-enhancing, cost-effective technologies. It reflects ProPAC's recognition that most of the requirements for funding technology in any given year result from the diffusion of existing technologies rather than from the introduction of new technologies. This allowance also reflects increased expenses attributable to changes in practice patterns that enhance quality and effectiveness but are not included in the allowance for real case-mix change.

In addition to this allowance, the Commission's recommended add-on for magnetic resonance imaging scans would increase payments to hospitals for technological improvement. ProPAC believes that targeted adjustments of this type should be offset in the DAF so that the total amount allowed remains unchanged by an add-on payment.

The scientific and technological advancement allowance does not reflect the anticipated changes in capital payments recommended by the Commission. Of the 3.9 percent increase in net intensity per case during the first eight months of 1985, as much as 1.0 percentage points can be attributed to capital expenses. If capital is added to the standardized amounts in fiscal year 1987 at a level lower than projected under current law, the scientific and technological advancement component of the DAF should be increased to reflect the additional appropriate capital resources required for funding this component of the DAF.

In developing the scientific and technological advancement allowance, the Commission recognized that the DAF was not the only source of financing technology adoption. As noted previously, the Commission expects that, during fiscal year 1987, hospitals will continue to be able to finance a portion of expenditures for new technology and improved practice patterns from gains in productivity. In addition, the increased operating margins that many hospitals appear to be achieving in the initial years of PPS are available to finance the implementation of scientific and technological advances.

Hospital Productivity.—The hospital productivity allowance in the DAF reflects the Medicare program's share of the potential changes in both efficiency and productivity resulting from PPS incentives to reduce the number and cost of resources for treating patients. The Commission adopted the position that it is both desirable and appropriate for productivity and efficiency gains to be translated into price reductions. The Commission also adopted the principle that such gains should be shared between the Medicare program, the Medicare beneficiaries, and the hospital industry. Productivity decreases, however, should not be directly subsidized by PPS.

Hospital productivity is difficult to measure due to problems in defining an appropriate output or product. Under PPS, the hospital product is defined as a discharge, as classified and labeled by the DRG system. At present, available data serve as an indicator of the potential for productivity gains but should not be viewed as direct measures of such change. The same data also frequently reflect changes in the types of services provided in inpatient and outpatient settings.

The potential for productivity gains was examined from a variety of perspectives, including changes in staffing patterns and length of stay and changes in the use of ancillary services. Historical trends formed the foundation upon which the Commission developed its productivity target for fiscal year 1987.

Although length of stay continues to decline, the rate of decline in 1985 was much slower than in 1984 (2.9 percent compared to 7.8 percent). A 2.9 percent reduction in length of stay cannot be directly or immediately translated into a 2.9 percent reduction in costs. The Commission believes, however, that for fiscal year 1987 such a decline could result in a 2.2 percent cost reduction associated with productivity gains, after accounting for real changes in case mix (Recommendation 3). In addition, changes in the use of ancillaries could contribute to between a 0.6 and a 2.5 percent reduction in costs. Savings from ancillary productivity gains, however, cannot be added in their entirety to savings from length of stay reductions. The estimates of length of stay savings reflect a 60 percent marginal cost assumption that includes some ancillary costs.

Since the Commission considers it appropriate for the industry to continue to benefit from the gains made in productivity, only a portion of these potential productivity gains are adjusted for in the DAF (minus 1.5 percent). The remainder of the potential cost savings is available to the industry to purchase improved technologies, to increase operating margins to fund future investments, or to offset costs associated with caring for more seriously ill patients who are not reflected in the real case-mix change adjustment.

Site-of-Care Substitution.—PPS provides significant incentives to change the nature of the hospital product, including incentives to shift services from an inpatient to an out-of-hospital setting or to move patients out of the hospital more quickly. Consequently, the services previously provided to patients during their hospital stay are now increasingly produced by using a mix of inpatient and out-of-hospital services. The Commis-

sion has termed this type of product change "site-of-care substitution." For patients admitted to the hospital, this shift in services would reduce the cost to the hospital of DRG production. Under these circumstances, the Medicare program and the beneficiaries could be overpaying for services since the cost base used to calculate DRG rates includes the costs of services that are now being provided in other settings.

Because of the implications for overpayment, the Commission has included an adjustment in the DAF that reflects the impact of site-of-care substitution on average inpatient costs per case. The allowance is not meant to reflect how diverting an entire admission to other settings would affect costs. An impact of this type of shift would be more appropriately considered under the real case-mix change adjustment. Instead, the allowance reflects the provision of services before and after hospitalization, which formerly were provided during the patient's inpatient stay.

The Commission's allowance for site-of-care substitution began with analyses of 1980-1984 data from a study conducted for ProPAC by the Commission on Professional and Hospital Activities (CPHA). These data compare average length of stay before and after PPS implementation. They reflect the impact of discharging a higher proportion of patients to other organized care settings and the effects of discharging these patients earlier than was the case before PPS went into effect. The data indicate a reduction in length of stay associated with higher proportions of patients discharged to alternative settings.

The analyses were limited to formal sites of care (e.g., discharge to nursing homes, discharge to home with home health services). They do not, however, reflect the substantial changes in site of follow-up care to physicians' offices or outpatient departments, the results of earlier discharge to alternative care settings, or increased use of preadmission services. Moreover, many hospitals were not on PPS or were on PPS only for a short period during 1984, and thus had limited exposure to PPS incentives for site substitution. The Commission believes that these early data from CPHA represent only a fraction of the site substitution that has occurred under PPS. Consequently, the Commission has specified an allowance of 0.6 percent to reflect its best judgment about the total effect of site substitution on reducing Medicare cost per case.

The Commission recognizes that the potential for productivity increases and site-of-care substitution is likely to diminish over time. Nevertheless, ProPAC continues to believe that there are substantial opportunities for achieving productivity gains during fiscal year 1987. Furthermore, it believes that site-of-care substitution has occurred and should be reflected in a reduction in the DAF.

Although separate allowances for quality or long-term cost-effectiveness of care were not established, the Commission treated these factors as overarching considerations in setting the level of the DAF and in examining each of the DAF components. More specifically, the Commission viewed quality and long-term cost-effectiveness as objectives to be achieved by implementation of rational payment policies. For more information on this recommendation, see Technical Appendix A.

Recommendation 3: Allowance for Real Case-Mix Change

Prospective payments should reflect real changes in case mix that are due to changes associated with the characteristics of patients and not changes simply due to better coding of records. The DAF allowance for real case-mix change should reflect both shifts in patients among the DRG categories, as measured by changes in the average case-mix index (DRG case-mix change), and changes in the mix of patients within DRG categories (patient complexity change). For the fiscal year 1987 payment rates, the allowance for real case-mix change should be set at 0.9 percent. This allowance represents a 0.2 percent adjustment for changes in the DRG case-mix index and a 0.7 percent adjustment for patient complexity changes.

In the April 1985 report, the Commission concluded that since PPS payments automatically reflect all changes in reported DRG case mix as they occur, an adjustment would be necessary to ensure that only changes in real case mix are built into future payment rates. To accomplish this, the

Commission recommended lowering all DRG weights to adjust for changes in DRG distribution but returning a portion of the lower payments to the hospitals through the DAF adjustment for real case-mix change. This adjustment was also intended to reflect changes in the complexity of patients within DRG categories.

The Commission did not actually specify a quantitative adjustment for real case-mix change in the April 1985 report. Quantification of the adjustment was provided in the Commission's comment on the Secretary's Notice of Proposed Rulemaking in July 1985. The Commission's estimate of real case-mix change was based on a preliminary study by the Rand Corporation. The Commission estimated that a 2.0 percent increase in reported case mix would occur during 1985. Of this increase, 0.8 percent was attributed to real case-mix change. This estimate reflected consideration of historical trends in real case-mix change, recent shifts to outpatient treatment, and within DRG patient complexity changes that would not be reflected in the DRG case-mix index.

For this report, the Commission has incorporated a 1.0 percent reduction in the DRG weights to account for observed changes in the DRG case-mix index during fiscal year 1986. Based on historical trends, the Commission estimates that the portion of this increase due to real changes in DRG case mix is 0.2 percentage points.

These figures may change as more recent data are reported. Currently, no data on DRG case-mix change for fiscal year 1986 are available. The most recent information is provided in another study by the Rand Corporation, which reports that the overall DRG case-mix index did not change from the fourth quarter of fiscal year 1984 through the second quarter of fiscal year 1985. The Commission believes, however, that while changes in the DRG case-mix index may have leveled off, it is consistent with recent experience to expect a small increase due to more accurate coding as hospitals continue to adjust to PPS and as hospitals in formerly waivered states (i.e., New York and Massachusetts) are brought into PPS for the first time.

Based on a study that CPHA conducted for ProPAC, the Commission has specified a 0.7 percent adjustment for increases in patient complexity during fiscal year 1986. This adjustment is a reflection of historical trends in length of stay associated with patient complexity changes that occurred in the two years before implementation of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). In that period, both Medicare and non-Medicare patients experienced approximately the same rate of increase in length of stay associated with increased complexity.

Between 1982 and 1983, significant increases in length of stay associated with greater complexity were found for both populations. The increase was substantially greater, however, for Medicare patients. During 1984, length of stay related to complexity decreased compared with 1983, but not to the level of the period preceding TEFRA enactment. The Commission has assumed that the increase between 1982 and 1984 was highly subject to the influence of improved hospital coding practices and may not represent actual changes in complexity. Thus, the Commission has based its estimate of real complexity change on hospitals' experience before 1983. The Commission has also assumed that a 0.7 percent increase in length of stay associated with increased complexity would translate into a 0.7 percent increase in costs. These estimates are subject to revision later in the year when data for 1985 will be available from CPHA. For more information on this recommendation, see Technical Appendix A.

Recommendation 4: Update Factor for Excluded Hospitals and Distinct-Part Units

For fiscal year 1987, the target rate of increase limits for the group of psychiatric, rehabilitation, and long-term care hospitals and hospital distinct-part units excluded from PPS should be updated to reflect the projected increase in the hospital market basket for these hospitals (corrected for forecast errors) minus a 0.8 percentage point adjustment for productivity and scientific and technological advancement goals established for PPS hospitals.

The target rate of increase limit for children's hospitals and distinct-part units should be updated to reflect the projected increase in the hospital market basket for PPS hospitals (corrected for forecast errors) minus a 0.8 percentage point adjustment for productivity and scientific and technological advancement goals established for PPS hospitals.

The PPS statute created two broad classes of hospitals—those that would be paid on the basis of DRGs and those that would not. Excluded hospitals—psychiatric, rehabilitation, pediatric, and long-term care hospitals (hospitals with unusually long average lengths of stay)—continue under cost reimbursement rules, which limit reimbursement per discharge. Both the PPS standardized amounts and the reimbursement limits for excluded hospitals are to be updated each year.

The types of patients seen and the treatment they receive vary significantly between PPS and excluded hospitals. The Commission believes it is appropriate to develop a separate update factor for the hospitals and units excluded from PPS but still subject to the target rate-of-increase limits. The Secretary has stated in the final rule governing PPS payments for fiscal year 1986 that the PPS statute requires application of the same update factor to both PPS and excluded hospitals. The Commission nevertheless reaffirms its position that the Secretary has the authority to establish a separate update factor for excluded hospitals. If, however, uncertainty about this authority remains, the Secretary should seek legislative change to obtain explicit authority for establishing separate rates of increase appropriate to the two different payment systems.

The update factor for excluded hospitals includes two allowances in addition to inflation: one for scientific and technological advancement, and another for productivity change. While it has been more difficult to quantify these concepts for excluded hospitals than for PPS hospitals, the Commission continues to believe that the update factors for both types of hospitals should include an adjustment for these elements.

Based on currently projected inflation rates, ProPAC estimates that this recommendation would lead to a 3.5 percent increase in the target limits for children's hospitals and distinct-part units, and a 3.7 percent increase for the rest of the excluded facilities. A summary of the Commission's recommendations for excluded hospitals appears in the table following this discussion.

These estimates are based on the assumption that capital expenses will not be brought under the target rate-of-increase ceiling. The Commission will reevaluate the appropriateness of its update recommendation if—and when—these payments are made subject to the target limits. In addition, the numeric value of the Commission's recommendations for excluded facilities will need to be modified as more recent forecasts of inflation become available.

The Commission reaffirms its 1985 recommendation calling for development of an inflation factor for the group of psychiatric and rehabilitation hospitals and units, and long-term care hospitals. The factor should reflect the mix of labor and nonlabor resources used by these hospitals rather than those used in PPS hospitals. This recommendation is based on the Commission's observation that the labor share of expenses in these hospitals is substantially higher than in PPS hospitals.

The Commission also continues to recommend using the PPS market basket to calculate inflation for children's hospitals. Analysis by ProPAC and others indicates that the labor share of total expenses in these hospitals is close to the overall average on which the current PPS weights are based. Thus, the PPS market basket weights are appropriate for children's hospitals.

The Commission currently estimates a fiscal year 1987 market basket inflation factor of 4.8 percent for psychiatric and rehabilitation hospitals and units, and long-term care hospitals, compared with 4.6 percent for PPS and children's hospitals. After applying a minus 0.3 percent factor to correct for errors in the 1986 market basket forecast, the net inflation-related adjustment in the fiscal year 1987 payment rates would be 4.3 percent for children's facilities and 4.5 percent for the remainder of the excluded facilities. This adjustment is likely to change after more current forecasts of market basket inflation are received later in fiscal year 1986.

While it might be appropriate to adopt scientific and technological advancement and productivity allowances reflecting the production functions of the various classes of excluded hospitals, insufficient evidence precluded doing so in this report. For fiscal year 1987 at least, the Commission has concluded that it is reasonable to incorporate the PPS allowances for scientific and technological advancement and productivity in

the excluded facilities' update factor. The Commission will continue to study the feasibility of developing separate allowances as a part of its long-term research agenda.

Two other adjustments included in the update factor for PPS hospitals, however, are not relevant to excluded hospitals.

First, the Commission reaffirms its 1985 decision not to incorporate any adjustment for real case-mix change in the DAF for excluded hospitals. Since excluded hospitals are not paid on a DRG basis, they have no incentive to upgrade the coding of cases. On the other hand, excluded hospitals may be experiencing increases in the acuity of illness in the patients they see due to the earlier transfer of sicker patients from PPS hospitals. At present, however, there are no data suitable for estimating the degree to which case mix may be changing in excluded hospitals.

Excluded hospitals are somewhat protected from these case-mix changes by an exceptions process that allows them to appeal their payment rates if they can demonstrate significant changes in case mix. The exceptions process is not only extremely cumbersome, however, but provides only retroactive relief. If relief is granted, it typically takes more than two years from the time excess costs are incurred. Therefore, it is unclear whether this exceptions process can adequately adjust for changes in case mix.

Second, the Commission believes that there is insufficient justification for including an adjustment for site substitution in the update factor for excluded hospitals. Compared with PPS hospitals, excluded hospitals have much weaker incentives and opportunities to shift services to other settings. As discussed above, these hospitals are much more likely to receive transfers from other facilities than to discharge patients early and refer them elsewhere. Under these circumstances, a positive adjustment for site substitution might be justified. At present, however, there are no data on which to base such an adjustment.

HCFA and others have conducted studies that have enhanced understanding of the differences between the PPS hospitals and excluded hospitals and units. Their relevance to development of the update factor is, however, limited. The Commission intends to continue to study excluded hospitals and to develop trend data relevant to the update factor. For more information on this recommendation, see Technical Appendix A.

Estimated Increase In Excluded Hospital Payment Limits For Fiscal Year 1987 Under Commission Recommendations

	Children's	Psychiatric/ Rehabilitation/ Long-term Care
Fiscal Year 1987 Market Basket Increase[a]	4.6%	4.8%
Correction For Market Basket Forecast Errors In Fiscal Year 1986[b]	−0.3	−0.3
Discretionary Adjustment Factor	−0.8	−0.8
Scientific And Technological Advancement	*0.7*	*0.7*
Productivity	*−1.5*	*−1.5*
Total Change	3.5	3.7

[a]DRI forecasts based on actuals through the calendar year 1985. This estimate takes into account the Commission's April 1985 recommendation for changing the treatment of wages in the hospital market basket.

[b]ProPAC estimate comparing DRI forecasts based on actuals through calendar year 1984 to forecasts based on actuals through the third quarter of 1985. The estimated adjustment here excludes errors in forecasting internal price proxies, as recommended by the Commission in its April 1985 report.

Capital

Recommendation 5: Including Capital in the Prospective Payment System

Beginning in fiscal year 1987, the Secretary should initiate a transition to all-inclusive prospective prices that combine operating and capital cost components in a single prospective payment per case for hospitals.

Retrospective cost-based reimbursement for capital lacks incentives for hospitals to restrain overall investment costs. Instead, it promotes insensitivity to interest rates and alternative financing methods. In addition, some hospitals may have invested in capital to produce services that exceed the demands of the inpatient hospital services market.

The combination of Medicare PPS and the capital pass-through has introduced additional distorted incentives to substitute capital for labor or other operating costs. As a result, the hospital that

can substitute capital for operating costs (and assume the risk of additional capital acquisition) receives more in total Medicare payments (i.e., hospitals receive fixed DRG payments plus increased cost reimbursement for capital expenditures).

The Commission strongly believes that the capital payment policy adopted should provide neutrality in capital/operating cost trade-offs. The payment method should not favor either capital or operating costs. Instead, it should encourage hospital managers to choose the optimal combination of these cost components. An all-inclusive payment rate would allow individual providers the flexibility to make what they consider to be the most cost-effective decisions based on the unique characteristics of their institutions.

The Commission is aware, however, that implementation of an all-inclusive rate at the levels set forth in its proposal may affect some hospitals disproportionately due to their individual financial positions. The Commission's proposal for capital payment, as explained in subsequent recommendations, may cause some hospitals to face significant cash shortfalls as a result of current and near-term obligations. ProPAC believes, however, that these shortfalls would not occur during the early years of the phase-in of its proposed capital policy. During this period, payments for capital should be sufficient to meet these hospitals' capital-related cash needs. Meanwhile, the Commission will monitor the implementation of the new capital payment system to identify potential problem areas for hospitals. Moreover, for reasons stated elsewhere, ProPAC believes that there should be no delay in implementing capital payment under PPS.

The Commission will continue to study the impact of its capital payment proposal on hospitals, focusing on those institutions that may be disproportionately affected by new capital payment policy. If the Commission determines that certain hospitals are unfairly treated by bringing capital payment into PPS, and that the quality and accessibility of care furnished to beneficiaries by these hospitals are jeopardized, it will develop and recommend appropriate remedies to the Secretary. For example, ProPAC will examine public and private sector options such as a hospital "borrow forward" program for financing capital expenditures.

The Commission intends to evaluate recent changes in hospital investment strategies and their impact on inpatient capital spending and the adequacy of future payments. Estimates of inpatient capital spending should be examined closely since recent capital expenditures may be heavily devoted to outpatient services. Furthermore, the addition of capital payments to PPS creates incentives for increased outpatient treatment due to the difference in reimbursement methods for inpatient and outpatient services. Finally, the Commission will study the impact of paying hospitals for capital based on the volume of Medicare services rather than on costs.

The Commission decided not to address the role of health planning in capital payment under PPS. It is aware that the PPS statute calls for required application of Section 1122 of the Social Security Act to regulate Medicare inpatient capital payment beginning in fiscal year 1987, and that proposals have been advanced to repeal this provision. The Commission expects that the Congress will deal with this issue in its legislative agenda for fiscal year 1987.

In summary, the Commission is concerned about these and other influences of new capital payment policy on all hospitals and specifically on disproportionately affected hospitals. ProPAC plans to study these issues and share its analysis with policymakers in order to achieve a capital payment policy that provides for the financial needs of hospitals while offering incentives for cost-effective decision making in the future. For more information on this recommendation, see Technical Appendix A.

Recommendation 6: Capital Payment Method

The Federal portion of capital payments should be computed as a fixed percentage add-on to the standardized amounts beginning in fiscal year 1987. The Secretary should immediately develop capital components to be added to the hospital market basket. When appropriate data become available, the components of PPS payments should be recomputed to reflect the addition of capital costs. The results of this recomputation should be implemented

as soon as possible, but no later than fiscal year 1988.

The Commission believes that developing an all-inclusive rate eventually requires recomputation of several components of the PPS system. Specifically, the addition of capital will result in new standardized amounts with new proportions for labor and nonlabor components. It may also require new adjustment rates for indirect medical education and any other adjustments in effect at the time capital is added.

The Commission's recommendation to recompute payment components will require data not currently available that reflect the addition of capital under PPS. The Commission believes, however, that distorted incentives exist under the current capital expenditures pass-through system that require a new payment policy to be implemented as quickly as possible. For this reason, the Commission recommends that an interim payment method of the percentage add-on to the standardized amounts be implemented beginning in fiscal year 1987. Recomputation of the payment system to reflect the addition of capital differs from the issue of recalculating the standardized amounts using new data for the purpose of changing the overall level of payments (Recommendation 13).

The Commission plans to study the impact of the addition of capital on other payment system components and appropriate proxies for capital costs in the hospital market basket. The Commission will also study whether adjustments for geographic variations in construction capital costs are appropriate.

The add-on should be applied in such a way that the distribution of capital payments will not be affected by the area wage index or the indirect teaching adjustment. Payment would, however, reflect case-mix variations and the differentiations associated with the national and regional standardized amounts. In addition, if the transition to national rates for operating payments is delayed, the Commission will consider whether the capital payment transition should be coordinated with the operating payment transition. For more information on this recommendation, see Technical Appendix A.

Recommendation 7: Level of Federal Capital Payment

Capital payment should be added to the Federal portion of PPS payments for hospital accounting years beginning in fiscal year 1987 at the following levels:

- **For building and fixed equipment, projected average Medicare actual capital costs per discharge for fiscal year 1985, trended forward to fiscal year 1987 by an index of construction capital costs.**
- **For moveable equipment, average actual Medicare capital costs per discharge for hospital accounting years beginning in fiscal year 1983, trended forward to fiscal year 1987 by an index of equipment capital costs.**
- **The proportion attributed to moveable equipment should be the lesser of the 1983 proportion or 40 percent.**

The Commission believes that the capital payment system should distinguish between two components: fixed capital (land, buildings, and fixed equipment) and moveable capital (major moveable equipment). This approach recognizes the differences between fixed and moveable capital expenditures and the differing effects of PPS payment incentives on hospital decisions regarding these cost components.

Moveable capital is purchased and turned over more frequently than fixed. For each year, in fact, the composition of moveable capital changes as assets are disposed of and replaced. Fixed capital is purchased infrequently and involves major capital expenditures, often requiring external review. Moveable capital purchase decisions often require hospital managers to make judgments regarding capital/operating cost trade-offs. Fixed capital, on the other hand, is not easily converted to another use, and related expenditures cannot be eliminated in the short-term. Financing of moveable capital may include leasing or use of a hospital's own funds in addition to borrowing. On the other hand, financing of fixed capital costs usually requires the use of debt or additional equity.

Furthermore, the time lag for purchase decisions, financing, and completion of fixed capital projects is typically several years. In some cases,

fixed capital expenditure decisions made by hospital managers before the introduction of PPS have not yet been fully implemented. Other fixed capital projects initiated in the early 1980s have just recently been completed, yet the related costs may not be fully reflected in current Medicare capital cost data.

For reasons stated above, the Commission believes that moveable equipment is more susceptible to the incentives of the current payment system for capital/operating cost trade-offs. ProPAC therefore recommends that 1983 be adopted as the base year for calculating moveable equipment payments since 1983 reflects a time when capital and operating costs were treated equally. Furthermore, the Commission believes that this approach would provide for control of Medicare expenditures without causing financial hardship for hospitals. This is because capital pass-through payments since 1983 have been sufficient for hospitals to recover a substantial portion of their 1983 moveable equipment costs.

The Commission recognizes, however, that hospitals recover fixed capital costs over an extended period. Moreover, since there is significant lag time for fixed capital projects, hospitals cannot respond as quickly to the incentives of a new payment system or to warnings about the future treatment of capital. The Commission selected the base year of 1985 because fixed capital costs reported in that year would reflect decisions made before PPS. For fiscal year 1987, the 1985 base year fixed capital costs will have to be estimated. When actual 1985 capital cost data become available, the Commission will compare these data with previous estimates and consider recommending adjustments, if appropriate.

The base year amounts for fixed and moveable capital should be trended forward to 1987. Separate indexes should be used that recognize the differences in cost trends between fixed and moveable capital. The Commission will study the data and application of these trending factors and will participate in determining the most appropriate indexes.

Federal payments for fixed and moveable capital should be based on Medicare's current definition of these cost components. All capital-related costs should be allocated to these components, including depreciation, interest, leases, rentals, insurance, return on equity, and taxes on depreciable assets used for patient care. The Commission believes that the current proportion of capital-related costs attributable to moveable equipment is no more than 40 percent. If, in monitoring the implementation process, it is determined that moveable equipment comprises more than 40 percent, the Commission recommends that the excess over 40 percent be included in the hospital-specific capital payments during the transition.

The Commission estimates that its proposal for the level of capital payment, combined with the transition plan (see Recommendation 8), will result in savings of approximately $8 billion compared to estimated cost pass-through payments during the next five years. For more information on this recommendation, see Technical Appendix A.

Recommendation 8: Capital Payment Transition

The transition to Federal capital payments under PPS should begin in fiscal year 1987 in accordance with the following provisions:

- **There should be no transition for moveable equipment. All payments for moveable equipment should be included as a fixed percentage add-on to the Federal standardized amounts beginning in fiscal year 1987.**
- **Payments for fixed plant and equipment should be phased in as a fixed percentage add-on to the Federal standardized amounts over a seven to ten year period on a straight-line basis.**
- **For plant and fixed equipment, hospital-specific capital payment portions should be the actual costs incurred during each year of the transition.**
- **During the transition, the Federal portion for plant and fixed equipment should be updated each year by an index of construction capital costs.**
- **The addition of capital to the Federal standardized amounts should reflect base-year treatment of return on equity and interest offsets. Return on equity payments should be added to the hospital-specific portion of operating payments.**

Once the transition to national rates for operating payments ends, there should be no hospital-specific payment for return on equity.

The purpose of a transition period for capital payments is to enable hospitals to position themselves to absorb the financial impact of the new capital payment system and to adjust their spending behavior accordingly.

The Commission considered several transition alternatives for moveable capital. It concluded that any transition period that would continue the cost pass-through for capital payments would perpetuate incentives for inappropriate hospital purchasing behavior. With the knowledge that moveable capital would eventually be included in PPS rates, hospitals would be encouraged to purchase and replace equipment unnecessarily during the transition, when a large portion of their hospital-specific costs would continue to be reimbursed.

The Commission believes that most of the costs related to moveable equipment acquired before the introduction of PPS have been already recovered. Therefore, a transition period is not necessary. A significant portion of payments for moveable capital would, in fact, support future purchases rather than the cash needs of prior purchases. Finally, the inclusion of moveable capital into the payment system without a transition provides funds immediately for hospitals that have not been able to afford equipment purchases.

The Commission believes that a relatively long transition period for fixed capital payments should be provided, however. The long-term commitments of individual hospitals for fixed capital must be recognized in the capital payment system. Unlike moveable capital, the costs related to fixed capital projects continue for many years. Hospitals must be provided the opportunity to position themselves in order to continue to meet the costs of fixed capital projects completed in the past. The Commission believes that a relatively long transition period will enable hospitals, regardless of their fixed capital commitments, to absorb the financial impact of the new capital payment system. If it is determined, however, that certain hospitals would be inappropriately disadvantaged during the transition, the Commission will consider options for assistance. (Refer to the discussion for Recommendation 5.)

Furthermore, hospitals should not be unduly penalized for fixed capital commitments made before the beginning of PPS, although it is difficult to determine the time of commitment due to the lags for fixed capital projects. In addition, some hospitals delayed fixed capital expenditures due to external constraints on construction or failure to secure needed funds. These factors make it difficult to select a threshold for fixed capital spending commitments. The Commission, therefore, recommends that hospitals' actual fixed capital costs be paid during each year of the transition. This will enable hospitals to meet their debt obligations while encouraging cost-effective decision making for construction and financing in the future.

The Commission recognizes that return-on-equity payments have been provided to investor-owned hospitals because cost reimbursement, in principle, does not afford an opportunity for these hospitals to earn profits. But DRG payments under PPS do provide opportunities for all hospitals to earn profits. The Commission believes it is unnecessary and undesirable to continue to pay return on equity in DRG prices. Therefore, return on equity should be phased out of hospital-specific payments for investor-owned hospitals in the same proportions and under the same schedule as the operating payment transition to national payment rates.

Proposals have been advanced to remove return on equity payments and to extend interest offset provisions to include interest earned on funded depreciation and donations. The Commission believes it would be inappropriate to remove these earnings from the Federal portion of capital payments to the hospital industry. Thus, it proposes including the associated revenues in the average capital payment per discharge calculations. Substantial reductions in capital payments, compared to current law, are already contained in the Commission's base year and trending recommendations. For more information on this recommendation, see Technical Appendix A.

Adjustments to the Payment Formula

Recommendation 9: Disproportionate Share Hospitals

An adjustment to the PPS rates for hospitals serving a disproportionate share of low-income patients should be implemented as soon as possible. This adjustment should specifically incorporate a definition and methodology in keeping with the character of the adjustments already being considered by the Congress. This adjustment should not change the total aggregate dollar amount paid to all hospitals.

This recommendation is a reaffirmation of a recommendation ProPAC made in the April 1985 report. The Commission remains convinced that hospitals serving a high volume of low-income patients (as measured by a variety of definitions) do incur higher Medicare costs per case. The update factor is likely to be constrained by broader government budget considerations. Consequently, the Commission is even more strongly convinced that a disproportionate share hospital adjustment should be implemented to provide equity to hospitals serving numerous low-income patients.

Although the Commission is pleased that the Congress addressed this issue as part of the reconciliation process, legislative change had not been enacted by the time this report was written. ProPAC is aware of the definition of disproportionate share hospitals published by the Secretary in the *Federal Register*, December 31, 1985. It believes, however, that this definition was not similar in character to the definition being developed in the Congress. In addition, the definition was not adequate to meet the special needs of disproportionate share hospitals and the beneficiaries they serve. The Commission hopes that further work by the Secretary will be more closely aligned with the intentions of the Congress.

Because the Commission is convinced of the seriousness of this issue, it intends to continue to study the consequences of changes in Medicare payment policies on the hospitals that serve disproportionate numbers of low-income patients. For more information on this recommendation, see Technical Appendix A.

Recommendation 10: Improving the Definition of Hospital Labor Market Areas

The Secretary should improve the definition of hospital labor market areas for fiscal year 1987, if possible, and no later than fiscal year 1988. For urban areas, the improved definitions should account for a greater amount of the wage variation between inner-city and suburban hospitals. For rural areas, the improved definitions should account for a greater amount of the wage variation between different rural areas within each state and between states. The implementation of improved definitions should not result in any change in aggregate hospital payments.

The Commission reiterates its belief that the current adjustment for area wage differences does not adequately account for the existence of separate labor markets within urban and rural areas.

In its April 1985 report, the Commission recommended that the Secretary develop and adopt improved definitions of hospital labor market areas. This recommendation was based on the results of studies that showed substantial variation between the wages paid by inner-city hospitals and the wages paid by suburban hospitals within the same Metropolitan Statistical Area (MSA). The Commission believed that the payment inequities resulting from this wage variation were substantial enough to warrant immediate correction.

Since this recommendation was made, the Commission has undertaken a study of hospital wage variation in both urban and rural areas using the most recently available HCFA data. The findings of this study, to date, support ProPAC's previous conclusion that substantial wage differences occur within many urban and rural areas.

The Commission believes that the most feasible approach for improving the definition of hospital labor market areas is to identify, wherever possible, additional labor markets within current area definitions. Alternative area definitions, such as the Bureau of Economic Analysis Areas (BEAAs) and Health Care Commuting Areas (HCCAs), do not account for a greater amount

of hospital wage variation than current area definitions. In the Commission's judgment, therefore, these alternative area definitions are not adequate replacements for the current area definitions.

The Commission's study suggests several promising and feasible approaches for identifying additional labor markets within current area definitions. Within urban areas, separating MSAs into central counties and surrounding counties accounts for a greater amount of hospital wage variation than the current areas. Within rural areas, the rural portions of BEAAs account for the greatest amount of hospital wage variation when compared to several alternatives. Separating rural counties into two groups (i.e., counties that are adjacent to MSAs and all others) accounts for an amount of wage variation comparable to the rural portions of BEAAs.

The Commission considers these approaches promising because they account for more hospital wage variation. In addition, they do not substantially increase the number of areas that contain only a few hospitals. ProPAC believes that labor market areas should contain a sufficient number of hospitals to prevent individual hospitals from having an inappropriate impact on their own area wage index. Therefore, the Commission recommends that any improvements in the definition of hospital labor market areas should not substantially increase the number of areas with a small number of hospitals.

The Commission is not yet prepared to make specific recommendations for improvements. Based on the preliminary findings of its study, however, it believes that improved definitions are warranted for both urban and rural areas. The Commission continues to believe that better definitions would substantially increase the equity of payments to some hospitals. ProPAC will provide specific recommendations to the Secretary before the completion of the rulemaking process for fiscal year 1987, if possible, and no later than April 1987. Furthermore, the Commission is prepared to share with the Secretary the preliminary findings of its ongoing study of hospital wage variation. For more information on this recommendation, see Technical Appendix A.

Recommendation 11: Rural Hospitals

In the original PPS legislation of 1983 and the Deficit Reduction Act of 1985, the Congress required the Secretary to study and report on a number of rural hospital issues. To date, none of these studies has been submitted to the Congress. Preliminary studies by the Commission suggest that there are potential problems in the way rural hospitals are treated under PPS. To facilitate open and informed public debate of rural hospital issues, the Commission urges the Secretary to complete and publish the congressionally mandated studies as soon as possible. If the results of the Secretary's studies indicate that changes in payment policies affecting rural hospitals are warranted, appropriate modifications to current policy should be implemented as soon as possible, including legislative change, if necessary. The Commission will continue its analysis of rural hospital issues and make specific recommendations in the future if findings indicate that changes in PPS payment policy are desirable.

Under PPS, various technical policies have been implemented that the Commission believes may adversely affect rural hospitals. Some of these effects result from policies applicable only to rural hospitals. Others result from policies that affect all hospitals, but that have a potentially stronger adverse impact on rural hospitals.

The PPS payment policy to calculate separate urban and rural standardized amounts reflects the historically lower average costs in rural hospitals. These cost differences remain even after adjusting for area wage differences, teaching activity, and DRG case mix. The cost differences partly reflect urban hospitals' larger size and wider range of services.

The differences also may be due to a triaging of more severely ill rural patients to urban hospitals, which is not reflected in the DRG case-mix index. A recent study by Health Economics Research, Inc. (HER) for HCFA suggests, however, that severity of illness explains no more than 1 percent of the cost difference between urban and rural hospitals. In contrast, the study indicates that a substantial portion of the cost difference can be accounted for by variations in medical practice patterns.

Whatever the underlying reasons for the cost differences, the establishment of separate standardized amounts has resulted in lower payments to rural hospitals. National standardized amounts were $2,985.05 for urban hospitals compared to $2,381.39 for rural hospitals in fiscal year 1985. The causes of the historical cost difference need further examination before permanently institutionalizing a two-tier payment system that potentially penalizes rural hospitals for historically achieving lower costs. This examination should include an assessment of the effects of a two-tier system on Medicare beneficiaries' access to or quality of care.

PPS payment policies related to outliers, area wage definitions, payments for DRGs with high device and low labor costs, and methods for calculating the standardized amounts further widen the difference between urban and rural average PPS payment levels. For further discussion of these policy issues, see Recommendation 10, 13, and 24 and Technical Appendixes A and B.

This discussion highlights technical issues related to the treatment of rural hospitals under PPS. Ultimately, however, the rural hospital policy debate may center on whether PPS, as currently structured, is appropriate for all rural hospitals. If it is not, the question is for which hospitals it is inappropriate.

In particular, the financial vulnerability of small rural hospitals to fluctuations in volume and case mix has caused concern. For larger institutions, minor fluctuations in volume and case mix are less critical. Larger hospitals can average these fluctuations from year to year and over a large number of cases. Small rural hospitals cannot take advantage of this "law of large numbers." If such hospitals are located in relatively isolated areas, and a deteriorating financial position results in closure of the facility, Medicare patients' access to services may be severely compromised.

Preliminary findings for 1984 indicate that hospitals in rural areas have experienced overall improvement in their financial position since implementation of PPS. The evidence regarding the first year of PPS should be viewed with caution, however. Given the reporting cycle of hospitals, many were not on PPS or were on PPS only for a short period in 1984. Moreover, recent evidence from the AHA's Panel Survey indicates that very small hospitals, the majority of which are rural, had negative patient revenue margins during 1985. Furthermore, these data provide little insight into the financial condition of hospitals under fully implemented national PPS payment rates or under all-inclusive rates encompassing capital and operating costs.

The Commission's PPS payments model indicates that, compared to the average experience of all hospitals, rural hospitals as a group would receive lower revenues per case as PPS moves to complete Federal rates. (See Technical Appendix C for further discussion of the effects of the transition.) Nevertheless, not all rural hospitals would lose under the system. Further analyses are required to determine which hospitals are jeopardized financially by Medicare's PPS policies and what, if any, technical adjustments would be appropriate.

In the end, the Congress or the Secretary or both may have to determine whether it is appropriate to pay slightly more money or to pay differently to avoid insolvency among certain small rural hospitals. That is, after correction for PPS' technical problems, small rural hospitals may still become insolvent due to declines or wide swings in volume or case mix or both. It may be cost-effective for Medicare to pay slightly more or slightly differently for care in these hospitals. This could be the case if, by doing so, rural patients are not required to seek care in distant urban hospitals where the care is less accessible and more costly. In this light, it will be important to analyze whether the current Sole Community Hospital provisions in PPS provide adequate adjustment for the problems of small, isolated rural hospitals.

In examining the potential cost-effectiveness of having Medicare pay more for services in isolated rural areas, it also will be important to assess the ability of other public funding sources to provide support for these hospitals. For example, 45 percent of the rural hospitals were government-owned in 1984. The question is the extent to which funding sources beyond PPS influence the continued ability of rural hospitals to provide services to Medicare beneficiaries.

Some of the policy issues outlined here are the subject of congressionally mandated studies. As a part of the legislation creating PPS (Pub.L. 98-21), the Congress required the Secretary to conduct studies on: 1) the feasibility and impact of eliminating or phasing out separate urban and rural rates; 2) an equitable method of reimbursing Sole Community Hospitals, taking into account their unique vulnerability to substantial variations in occupancy; and 3) appropriate payment policies for large rural teaching hospitals. In addition, the Deficit Reduction Act of 1985 (Pub.L. 98-369) required the Secretary to review and report to the Congress on the appropriateness of urban/rural differential payments as they apply to DRGs with high nonlabor costs (e.g., device and supply costs). These studies have not yet been submitted to the Congress.

While the studies do not address the complete range of issues outlined by the Commission, they are likely to provide valuable baseline information for analyzing the impact of PPS on rural hospitals. The Commission, therefore, urges the Secretary to complete and publish the findings from the congressionally mandated rural hospital studies as soon as possible. The Commission also will continue to analyze rural hospital issues. It is prepared to share with the Congress and the Secretary its findings as they are developed. For more information on this recommendation, see Technical Appendix A.

The Standardized Amounts

Recommendation 12: Earlier Availability of Medicare Cost Data

The Commission is pleased that the Secretary has taken steps to speed up the availability of Medicare Cost Report data from the first year of PPS. The Commission recommends that making cost data available as soon as possible be an ongoing effort, since these data are vital both to assess the relationship between PPS payments and hospital costs and to analyze the costs of individual DRGs. As part of this ongoing effort, alternative strategies for sampling hospital cost data should be considered. The necessary additional resources should be allocated for timely processing of these data.

More timely cost data are essential for improving PPS and understanding how it affects hospitals. Cost data are needed to assess the appropriateness of the overall level of PPS payments, to examine the ways in which hospitals have reacted to the PPS incentives to lower costs, and to analyze the costs of individual DRGs and services. The Commission has felt at a disadvantage in making recommendations based on 1981 cost reports because these data do not reflect the effects of PPS or other recent changes that are likely to have changed hospital costs.

Most hospitals have accounting years that begin after the Federal fiscal year. Consequently, there is a considerable lag in obtaining a complete set of cost reports. For example, the set of cost reports from the first year of PPS, which began in October 1983, will include hospitals with accounting years that ended as late as August 1985. Hospitals have three months to submit the report, and additional time is needed for the fiscal intermediary to enter the data into the automated data processing system. Even more time is needed to complete an audit. It can take up to a year after the end of the hospital accounting year until final settlement is made.

Because of this time lag in obtaining a complete set of cost report data, accelerating the availability of cost data requires developing a sample of hospitals. Data from a sample will not be as thorough as data ultimately received on all hospitals. The extent of the errors is predictable, however, and the benefits of having more recent information outweigh the disadvantages.

HCFA has tried to speed up the compilation of cost data from the first year of PPS. Unaudited cost report data for all PPS hospitals were expected centrally at HCFA by February 1986. In addition, audited data from a sample of 1,200 hospitals were expected by March 1986. Audits would normally be performed in the order in which hospitals submit their cost reports. This sample was chosen so that audited data on a representative group of hospitals would be available earlier. Unfortunately, neither data set was available in time for the Commission to use in its deliberations for this report.

Statistical analysis performed for the Commission by the Rand Corporation indicates that HCFA's audit sample, when weighted for sampling by census region and bedsize, is represent-

ative of those hospitals used to create the current standardized amounts. For the most part, the weighted audit sample differs little from the overall set of hospitals by urban and rural status, Census Division, or bedsize (see Technical Appendix A). Further analysis needs to be done, however, before the Commission can comment on the precision with which the sample could be used to estimate costs for different groupings of hospitals.

Alternative strategies for sampling as-submitted (unaudited) and audited cost report data should also be considered. In particular, analysis is necessary to test the feasibility of developing a representative sample of PPS hospitals from the subset of hospitals with relatively early accounting year end-dates. If such a sampling method is practical, a set of unaudited cost report data could be developed much earlier in the year. The Commission intends to examine this approach, and would like to work with the Secretary in determining its feasibility.

Recommendation 13: Recalculating the Standardized Amounts

The standardized amounts used to determine hospital payments under PPS should be recalculated using cost data that reflect hospital behavior under PPS. The results of such a recalculation, with appropriate modifications, could be used in determining the update factor or in rebasing the standardized amounts.

Periodic recalculation of the standardized amounts would provide information about the relationship between hospital costs and PPS payments that could be valuable in setting future payment levels. Even though PPS was designed to break the direct link between each hospital's costs and the payments it receives from Medicare, payments on average should be reasonably related to costs. Using cost data as an input to PPS price-setting decisions does not interfere with hospital incentives to achieve greater efficiency.

The goal is not to return to cost reimbursement, but to use information about costs to maintain the PPS incentives for efficiency without adversely affecting quality of care. If average payments are much higher than average costs, Medicare may be spending more than necessary. Payments that are equal to or below costs may create financial problems for hospitals, which ultimately could affect beneficiary access to quality care. Analyzing the relationship between average costs and average payments is particularly important in the early years of PPS. Decisions about the size of the update factor have partly been based on judgments about the extent to which hospitals could increase their productivity and lower their costs. Reviewing more recent cost data is the best way to assess the accuracy of these judgments.

Some information about the relationship between costs and payments can be gleaned from indicators of the overall financial condition of hospitals, such as financial ratios and evidence of hospital closures. This information is indirect, however, since many factors other than Medicare payments might be involved. In addition, the interpretation of financial ratios is often controversial.

Once the standardized amounts are recalculated, the results can be used in two ways. Recalculated standardized amounts could be one piece of information used to select an update factor. Alternatively, the standardized amounts could be rebased—that is, the recalculated amounts could be updated and substituted for the current published rates.

The distinction between using recalculated standardized amounts in determining the update factor and using them to rebase is not as great as it may appear. Rebasing is not a complete substitute for choosing an update factor, since the recalculated payment amounts would have to be updated from the data year to the payment year. For example, the most recent cost data available to HCFA are for hospitals' first year on PPS. These data would have to be updated by as much as three years—to the end of Federal fiscal year 1987.

If the decision is made to rebase the standardized amounts, several other choices must be made. These include the frequency of rebasing and the possibility of setting a limit on how much effect rebasing could have on the standardized amounts.

A further choice involves the method used to average the standardized amounts. The current standardized amounts are hospital-weighted, so

that the resulting standardized amount represents the costs in the average hospital. An alternative method would be to discharge-weight the average, so that the standardized amounts represent the average cost of treating a case.

The redistributional effects of changing the averaging method would have to be considered. Discharge-weighting the national urban and rural amounts would result in a 3 percent increase in payments to rural hospitals and a 0.5 percent decrease in payments to urban hospitals. This result happens because there are many very small, low-cost rural hospitals with relatively few Medicare discharges that count more toward the current hospital-weighted average than they would toward a discharge-weighted average. For more information on this recommendation, see Technical Appendix A.

Recalibration

Recommendation 14: Recalibrating the DRG Weights

The DRG weights should be recalibrated annually in order to reflect the use of new technologies and other practice pattern changes affecting the relative use of hospital resources among the DRGs.

Since the PPS statute requires recalibrating the DRG weights at least every four years, the decision to recalibrate more frequently could be made on an ad hoc basis each year. The Commission believes, however, that a recalibration schedule should be set in advance so that the hospital industry can anticipate when changes in the weights will occur. Such a schedule is consistent with the prospective nature of PPS, which is designed in part to make Medicare payments more predictable for both hospitals and the Federal government.

Moreover, the Commission believes that the schedule for recalibration should be annual. Given how quickly practice pattern changes that affect relative resource use among the DRGs can occur, the four-year maximum cycle is clearly too long to keep the weights current. Even with an annual cycle, the most current patient billing data will be two years older than the year for which the weights are set (e.g., fiscal year 1985 data for fiscal year 1987 payment).

Less frequent recalibration would lead to greater changes in weights when recalibration occurs, and would also require making a greater number of interim adjustments to individual DRGs in lieu of recalibration. The Commission expects that the weights for most DRGs would not change much under annual recalibration. Large changes are possible for a few DRGs if, for example, a new medical device is being used, or many patients are being shifted to outpatient treatment.

The Commission considered the extent to which annual recalibration would pose a burden on hospitals. Frequent recalibration would require hospitals that compute their case-mix index to modify computer software to reflect the new weights. In addition, annual changes in the weights may make it more difficult for hospitals to predict their Medicare revenue. In both cases, however, the feedback from hospitals indicates that the benefits of more current relative DRG prices far outweigh any costs associated with annual recalibration.

The Commission is aware that if a recalibration is carried out for fiscal year 1987, the 1986 weights would have been in place for only six months because implementation of the weights recalibrated for fiscal year 1986 was delayed. Nevertheless, the Commission believes that the DRG weights should be based on the most recent data possible and that, despite the delay in 1986, the annual recalibration cycle should be continued for fiscal year 1987.

The Commission defines recalibration as a two-step process. First, new DRG relative weights are computed using the most recently available data. Second, the new weights are normalized (adjusted by a scaling factor) so that the average case weight after recalibration is the same as it was before recalibration. The Commission considers normalization an integral step in recalibration to ensure that recalculation of the relative weights does not affect aggregate payments to hospitals.

After recalibration, the DRG weights should be adjusted to remove any demonstrable change in reported DRG case mix that occurred during the previous fiscal year. This adjustment would ensure that changes in DRG case mix due to im-

proved coding would not be built into future PPS payments. Changes in payments due to real changes in the types of patients treated should be allowed, however, as discussed in Recommendation 3.

For this report, the Commission has incorporated a 1 percent reduction in the DRG weights to account for observed changes in the DRG case-mix index during fiscal year 1986. This figure may change as more recent data are reported. Currently, no data on DRG case-mix change for fiscal year 1986 are available. The most recent information is provided in a study by the Rand Corporation, which reports that the overall DRG case-mix index did not change from the fourth quarter of fiscal year 1984 through the second quarter of fiscal year 1985. The Commission believes, however, that while changes in the DRG case-mix index may have leveled off, it is consistent with recent experience to expect a small increase due to more accurate coding as hospitals continue to adjust to PPS. Moreover, hospitals in New York and Massachusetts would be particularly prone to coding improvement since they only recently began participating in PPS.

For fiscal year 1986, the Commission recommended recalibrating the DRG weights, using charge data alone. Prior to the beginning of fiscal year 1986, the most recently available cost data were from hospital accounting years ending during fiscal year 1982, two years before the implementation of PPS.

HCFA has attempted to collect Medicare Cost Report data for the first year of PPS in time to be used during the rulemaking process for fiscal year 1987. These cost data should be used along with the charge data from the fiscal year 1985 PATBILL data set for recalibrating the DRG weights for fiscal year 1987, if they are available. Otherwise, the charge data should be used alone. Analyses of 1981 data have shown that weights based solely on charges differ only slightly from weights based on charges adjusted for costs. Changes in charge-setting practices in recent years may lead to greater differences between the weights, but more recent data must be analyzed before reaching this conclusion. If capital is added to PPS, cost weights should reflect capital as well as operating costs.

Beneficiary Concerns

Recommendation 15: Beneficiary and Provider Information

The Secretary should take immediate action to provide more and better-written information about the Medicare prospective payment system to beneficiaries and providers of care. The Department should work with providers, beneficiaries, and associations of these groups to produce and disseminate this information. Associations of providers and beneficiaries should also increase their own efforts to better educate and inform their members about the Medicare prospective payment system.

Negative perceptions of the quality of care received under the prospective payment system are widely held and have received increasing attention. Some of these negative perceptions may not reflect the actual quality of the care received; rather, they may flow from misperceptions about PPS communicated to the beneficiary. The Commission particularly takes note of reported instances in which the average lengths of stay for the DRGs, as published in PPS regulations, have been used either implicitly or explicitly to limit a patient's hospital stay. The instances, for example, include patients being told it is time for them to leave because "their DRGs have run out." In addition, some hospital notices of noncoverage are apparently predicated on a notion that a patient's DRG length of stay limit has been reached. The Commission emphasizes that published lengths of stay for each DRG should be regarded as averages. It is inappropriate to apply them as absolute limits.

The Commission urges considerably greater educational efforts to inform beneficiaries about PPS. Although the payment system began in most hospitals during late 1983 and early 1984, it was not until the spring of 1985 that HCFA made available any general purpose information aimed at beneficiaries explaining some of the common misperceptions about the system. It was not until February 1986 that HCFA mandated that hospitals inform patients of their appeal rights with respect to discharge decisions. Even today, there is no general PPS fact sheet or information available nationally from HCFA, for either beneficiaries or providers, including physicians.

These groups badly need such information—particularly hospitals and physicians—because they are often called upon to explain the system to the beneficiaries, who have no other available information source. The Commission applauds HCFA's plans to develop such information for beneficiaries. It is not aware, however, of any plans for similar efforts to educate either hospital personnel or physicians. HCFA should make every effort to ensure that materials are widely available to both providers and beneficiaries.

In addition to an increased effort within HCFA and other appropriate HHS organizations, ProPAC also encourages other provider and beneficiary organizations to assist in this important but complex educational effort. The Commission commends efforts by groups such as the American Association of Retired Persons for the materials that they have already developed. It encourages other organizations to develop and disseminate educational materials to their members, patients, and the general public.

Recommendation 16: Notice to Beneficiaries of Rights

Beneficiaries should be made aware of the process of reconsideration and appeal of a hospital denial of coverage for continued inpatient hospital care. Notification should be through a written notice or information bulletin. It should explain beneficiary rights in a clear, helpful, and understandable manner. In addition to a clear statement of rights, the bulletin should inform beneficiaries that they should not accept any oral communication to the effect that they must leave the hospital because their "coverage" has "run out" or because there is a limit on the number of days "allowed" by Medicare for a DRG. The bulletin should be distributed at the time of admission or as soon thereafter as is appropriate based on the patient's clinical condition. However, additional avenues of distribution should also be developed.

HCFA provides, by regulation, that beneficiary coverage for continued inpatient care may be denied if a hospital determines that the beneficiary no longer requires this care. The beneficiary may appeal this denial. The hospital is not required to give such notice to a beneficiary routinely, but only when it intends to charge the beneficiary for continued stay. The PROs are responsible for monitoring the denial notices to see that they are correct and do not mislead the beneficiary or misstate the authority or responsibility of the hospital in issuing the notice.

In February 1986, HHS announced the development of a one-page summary of information describing the patient's rights. The hospital is to give this bulletin, entitled "An Important Message from Medicare," to each Medicare beneficiary upon admission. HHS developed the bulletin after careful consultation with a group of organizations representing Medicare beneficiaries and national health care provider organizations. The bulletin will fulfill the intent of this recommendation, and ProPAC commends the Secretary for the action that has been taken.

The Commission regards this bulletin as a critical first step in providing information to beneficiaries. Because it has not yet been distributed to hospitals, and its usefulness to beneficiaries is not yet known, the Commission has chosen to submit this formal recommendation. ProPAC will continue to monitor the use and usefulness of this bulletin.

Further, the Commission maintains that the Secretary should not limit distribution of the bulletin to the time of beneficiary admission. The Secretary should make every effort to distribute it at other appropriate times. Copies could be made available at offices of the Social Security Administration, for example, and in various Medicare program and Social Security Administration mailings to beneficiaries. They could also be distributed through the auspices of associations and other groups involved in health care for the elderly.

Recommendation 17: PRO Episode of Care Review

The focus of PRO quality of care review should be, to the extent possible, on the entire episode of care. The PRO's review should include, in addition to the period of hospitalization, the quality of care (and outcome) related to the overall episode of illness, including, if appropriate, skilled nursing or home health care.

A primary determinant of the quality of care administered to a hospital inpatient is the outcome

of the episode of care. Changed financial incentives under PPS, and changing patterns of care, are resulting in less frequent use of the hospital and more frequent use of skilled nursing facilities, other community facilities, and the patient's home for treatment.

The quality and level of care available to beneficiaries in these alternative settings directly influence, therefore, the outcomes of the illnesses or problems for which beneficiaries were originally hospitalized. They can directly affect the overall quality of care beneficiaries receive. The problem of premature discharge, for example, may not be insufficient hospital services, but rather inadequate clinical management of the post-acute patient.

The focus of PRO review should, therefore, be on quality of care and patient outcomes as measured over the entire spectrum of services provided—institutional and ambulatory. Quality-of-care monitoring during the course of inpatient care should be strengthened. Medical status at the time of discharge should be determined to deter and prevent premature discharges, and the availability of alternative services in the community should be determined. In addition, outcome measures such as follow-up data on patient survival and functional status should be established and applied. A pilot program of long-term review, based on an appropriate sample of beneficiaries and including outcome measures, should be instituted.

Recommendation 18: PRO Review of Outpatient Surgery

The Commission is concerned that efforts to shift surgical services from the inpatient to the outpatient setting could have an adverse impact on quality of care for certain Medicare beneficiaries. The PROs should be required to review and monitor the quality of care (and outcome) of outpatient surgery for selected patients and procedures. As a starting point, the PROs should be required to review outpatient surgery cases for those procedures that have been identified for preadmission review, including in particular a sample of those cases for which the PRO has denied payment on preadmission review.

An increasing number of surgical procedures that previously were performed on an inpatient basis are now being performed in ambulatory settings. The movement of surgical services from the inpatient to the outpatient setting has been further encouraged by HCFA policies requiring PROs to reduce admissions for procedures that could be performed in an ambulatory surgical setting. This has been accomplished through various review mechanisms, including preadmission review, random sampling for short stays, and the establishment of admission reduction objectives.

The Commission supports efforts to encourage performance of procedures in the most appropriate setting. It believes, however, that the impact of this shift on the quality of care furnished Medicare beneficiaries must be examined.

The Commission is aware that review of outpatient surgical cases is a significant expansion of the PROs' responsibilities. The PROs, however, are already required to perform preadmission review and to deny payment for procedures that could appropriately be furnished on an outpatient basis. The Commission believes that it is a reasonable next step to require the PROs to review the quality of outpatient care where payment for inpatient care has been denied. Further, since both HCFA and the PROs have developed criteria regarding procedures they deem appropriate for ambulatory settings, the cases undergoing outpatient surgery procedures established by these criteria should also be reviewed. In addition, categories of patients who may be at high risk because of outpatient surgery, such as the frail elderly, deserve special concern.

Recommendation 19: Recalculating the Inpatient Hospital Deductible

The Secretary should seek legislative change to the formula for computing the inpatient hospital deductible so that the annual increase in the deductible is more consistent with the annual per-case increase in Medicare payments to hospitals. The proportion of the costs of inpatient hospital care borne by Medicare beneficiaries has inappropriately increased as a result of significant declines in length of stay experienced since the beginning of PPS. This proportion should be lowered to its calendar year 1983 level.

Medicare beneficiaries pay a deductible for each hospital stay, unless they have already paid the deductible during a benefit period. A benefit

period, or spell of illness, begins on the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or a skilled nursing facility for 60 days or more.

The formula for computing the inpatient hospital deductible, currently specified by law to approximate the average cost of a hospital day, is updated annually on a calendar-year basis. For 1986 the deductible is $492, up from $400 in 1985. The HCFA actuaries have estimated that beneficiary liability will increase by about $1.1 billion as a result of this update. Although most beneficiaries have supplemental insurance coverage that pays the Medicare deductible, increases in the deductible are reflected in higher premiums for this coverage.

About half the increase in the deductible for 1986 is due to the decline in length of stay attributable to PPS incentives. The deductible calculation is based on data for calendar year 1984, when the average length of stay for the over 65 population was 9.0 days, compared to 9.7 days in 1983. In the *Federal Register* notice announcing the new deductible calculation, HCFA stated that the large increase in the deductible would probably be limited to 1986 because the decline in length of stay was expected to level off.

Data from the American Hospital Association Panel Survey indicate that length of stay for patients over age 65 declined slightly during 1985, however. This suggests that another increase in the deductible related to decreasing length of stay would occur for 1987 under the current formula. The Panel Survey reports that length of stay for the over 65 group fell from 9.0 days to 8.8 days in the first 11 months of 1985.

Although the deductible approximates the average cost of an inpatient day, it was never intended to increase as a result of shorter lengths of stay. The Senate report accompanying the original Medicare legislation stated that the deductible should ". . . keep pace with hospital costs." Further, the current regulation states that "the result of the deductible increase is that the beneficiary continues to pay about the same proportion of the hospital bill."

Savings from shorter length of stay have benefited both hospitals and the Federal government, and the Commission believes that Medicare beneficiaries should share in these gains as well. Hospitals have gained from the decline in length of stay because they keep the difference between the PPS payment and their costs for treating the Medicare patients. The Federal government has also benefited since the decline in length of stay has been one of the factors considered in limiting increases in PPS rates.

The deductible should be calculated so that the proportion of total payment per stay borne by the beneficiary is the same as it was in calendar year 1983. In this way, the increase in the deductible would reflect the increase in Medicare payments per case and would not be affected by changes in length of stay since PPS began. Medicare beneficiaries would also then benefit from reduced increases in Medicare payments to hospitals over time. ProPAC estimates that the 1983 beneficiary share of payments was about 8.5 percent. Applying this proportion to the current forecast of 1986 hospital payments would yield a 1986 deductible of $400.

A change in the deductible would also affect Medicare coinsurance. Medicare hospital inpatients pay coinsurance equal to 25 percent of the deductible for days 61 through 90 of the benefit period. After 90 days, beneficiaries can choose to draw from a lifetime reserve of 60 hospital days, which are subject to a coinsurance amount equal to 50 percent of the deductible. In addition, coinsurance on Medicare-covered days in skilled nursing facilities is equal to 12.5 percent of the inpatient hospital deductible.

It may be appropriate to reconsider the overall structure of beneficiary cost-sharing in light of PPS incentives and policies. For example, some of the patients who are required to pay coinsurance are outlier patients—those patients whose stays are sufficiently long to warrant additional payments to the hospital. The coinsurance payments in isolated cases may be equal to or greater than the outlier amount that Medicare would have paid the hospital for these days. The Commission will study issues related to restructuring beneficiary cost-sharing that are suggested by changes in hospital practice associated with the incentives of PPS.

Patient Classification and Case Mix

Recommendation 20: Improving the Measurement of Hospital Case Mix

The Commission believes that the DRG system is currently the most appropriate of the available measures of hospital case mix for the Medicare PPS and should be retained in principle as the system upon which to base Medicare payments to hospitals. Resource use varies considerably, however, within some DRGs. Therefore, the Commission intends to continue its analysis of individual DRGs and to undertake a systematic evaluation of the entire system. The goal is to identify potential problems in DRG construction and classification and to recommend changes that will improve the homogeneity within DRGs and the equity of payments across hospitals.

The Commission has previously identified potential weaknesses with the use of DRGs for prospective payment. In its April 1985 report, ProPAC outlined several areas for further analysis to improve the measurement of case mix. These areas included DRG construction and classification, heterogeneity within DRGs, and case-mix distribution across hospitals that results in inequitable payments.

The April 1986 report contains a number of analyses of specific technologies and DRGs. To date, such analyses have been on a case-by-case basis. In some instances, ProPAC has recommended reclassifying a subgroup of patients, such as those receiving penile protheses, into different DRGs. In others, the Commission has recognized the need to restructure a group of DRGs; for example, hand procedures, DRGs 228-229. The Commission has also concluded that some DRGs may be heterogeneous, but that further analysis is necessary before specific recommendations are made; DRGs 456-460, for burns, are illustrative.

ProPAC has examined three broad approaches for improving case-mix measurement. Described in the April 1985 report, these approaches were to: 1) retain the current system, but revise it in an incremental fashion as problems are revealed; 2) retain the current system in principle, but reconstruct it using a newer and more complete data base; and 3) consider an alternative case-mix measurement system, either in conjunction with DRGs or to replace DRGs.

The Commission believes that the assignment of cases into individual DRGs should continue to be monitored and updated in response to changes in medical practice, medical technologies, and diagnosis and procedure coding. The Commission will continue, therefore to evaluate the assignment of cases into specific DRGs.

Furthermore, ProPAC has concluded that additional evaluation and analysis are necessary before replacing or modifying the DRGs using an alternative case-mix system. Currently, there are no generally accepted criteria for evaluating alternative systems. In addition, a comprehensive, comparative evaluation of all the alternative case-mix systems has not yet been performed. The Commission is aware of several comparative studies that are under way. It will continue to monitor the results of these studies.

The Commission has identified problems in the DRG assignment criteria, which may produce heterogeneity within DRGs or result in an inequitable distribution of patients across hospitals. Nevertheless, ProPAC does not recommend a major reconstruction of the system at this time. Unless the assignment criteria are changed, reconstruction would not necessarily produce a more homogeneous DRG system.

In the short-term, a systematic evaluation of the DRG system can identify areas for improvement to the current system. The evaluation may identify the need for changes in DRG assignment criteria, such as alternative complications and comorbidities; modification in grouping methodology, such as combinations of diagnoses or identification of specific devices; or refinements in policies, such as outlier payments. In addition, the Commission is aware of several studies to evaluate modifications of the DRG system using additional clinical variables. It will continue to monitor the results of these studies.

Recommendation 21: Process for Maintaining and Updating ICD-9-CM

The Secretary should establish a mechanism for maintaining and updating ICD-9-CM diagnosis and procedure codes in a timely and effective manner. This process should include adequate educational support for all users.

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The DRG system uses ICD-9-CM diagnosis and procedure codes to assign each Medicare hospital discharge to a specific DRG for payment purposes. In order for the DRG system to remain current and accurate as medical technologies and practices change, the ICD-9-CM coding system must be updated. However, the ICD-9-CM classification, developed almost ten years ago, is not due for a major official revision until 1993. The current timetable and process for revision will not provide users with new or revised codes in a timely and effective manner. While this lengthy revision process is necessary to meet international commitments and satisfy needs for international data compatibility, it is inadequate to address more immediate problems experienced by ICD-9-CM users in the United States.

The Commission recognizes recent efforts to accommodate the need for shorter-term revisions to the ICD-9-CM system. Especially noteworthy is the recent organization of a HCFA/National Center for Health Statistics (NCHS) ICD-9-CM Coordination and Maintenance Committee, which is composed of representatives from various Federal agencies. The committee is responsible for considering errata and addenda as well as other modifications of the ICD-9-CM to reflect new procedures and technologies, recently identified diseases, and other coding problems. It is also charged with promoting the use of Federal and non-Federal educational programs and other communication techniques to standardize coding applications and upgrade the quality of coded medical data.

The ICD-9-CM Coordination and Maintenance Committee has begun to address some of the same coding issues the Commission has studied. The committee's recommendations on proposed coding changes for fiscal year 1987 are expected to be published in the *Federal Register*. ProPAC supports the committee's efforts to effect revisions or modifications to the ICD-9-CM as soon as possible. The Commission recommends that such changes be made to coincide with Grouper changes.

The Commission is concerned, however, that the committee has not publicly identified the specific procedures and processes it will follow. The committee currently plans to consider, on an ad hoc basis, coding changes requested by members and other interested parties, such as industry representatives. The committee's decisions regarding modifications to the ICD-9-CM must be formally accepted and issued, however, by NCHS and HCFA.

It is unclear whether the committee can and will have revisions or modifications available for use in a timely manner. Further, there is no clear relationship between this committee and the AHA central coding office concerning ICD-9-CM. The Commission also questions the lack of representation on the committee of non-Federal users of ICD-9-CM, and the extent to which the committee will be able to resolve disputes about the use of existing codes.

The Commission believes that the need for accurate timely coding decisions is vital to PPS. It is concerned that the committee will be unable to carry out its many responsibilities in a timely and effective manner. ProPAC is further concerned that the committee will be unable to provide it with advice soon enough for the Commission to carry out its responsibilities to consult with the Secretary before rulemaking. If this process does not ensure timely and effective changes, the Commission recommends adopting an alternative mechanism expeditiously.

The Commission also recommends that appropriate educational material for users accompany all revisions or modifications to ICD-9-CM. Such educational support is necessary to ensure the dissemination of revision notification and to help ensure consistency in code assignments.

Recommendation 22: Process for Interpretation and Assignment of Existing Codes

The Secretary should ensure that interpretation and assignment of existing ICD-9-CM diagnosis and procedure codes for payment purposes strictly adhere to coding rules and guidelines. In order to maintain the integrity and uniformity of the coding system while allowing flexibility for payment purposes, the process for interpretation and assignment of existing ICD-9-CM codes should be assigned to one authorized group.

The Commission recognizes that it is important to maintain the integrity and uniformity of the ICD-9-CM coding system. At the same time, the system must provide a consistent mechanism for data reporting for Federal users and others. The system must also be flexible enough to be used by Medicare for payment purposes. Coding decisions related to payment should not violate coding rules and guidelines.

Decisions related to the interpretation and assignment of existing codes are critical for all the purposes for which codes are used. Besides maintaining and updating ICD-9-CM diagnosis and procedure codes discussed in Recommendation 21, there is a continuing need for interpreting and assigning existing codes. The AHA has performed this service since the mid-1960s under contract with NCHS. NCHS, HCFA, and the American Medical Record Association (AMRA) must concur with all of AHA's decisions. However, other groups, such as commercial abstracting services, also make coding decisions and provide coding information. This may have led to the dissemination of conflicting coding advice.

The expanded use of ICD-9-CM for payment intensifies the need for a central authorized source to address concerns about coding. The overlapping activities of AHA's central coding office, the HCFA/NCHS ICD-9-CM committee, and other groups should be clarified; the responsibilities of each group should be clearly defined. The designated group should also be responsible for providing official endorsement of coding manuals. A number of written coding references now exist without any official authorization.

Recommendation 23: Interim Mechanism for Coding Problems

The Secretary should establish an interim mechanism to allow early identification of new technologies, procedures, and diagnoses and more appropriate DRG assignment when ICD-9-CM codes cannot be updated in a timely manner.

The Commission's experience with coding problems, including inadequate coding of new and changing technologies and procedures, has illustrated the deficiencies and rigidities inherent in the current ICD-9-CM coding system. Besides the long-term improvements proposed in Recommendations 21 and 22, the Commission thinks a rapid, responsive interim mechanism is necessary to permit early identification of new technologies, procedures, and diagnoses. Such a mechanism would allow more flexibility—and therefore more appropriate DRG assignment—as problems are identified. The mechanism could also be used at times independent of changes in Medicare coverage policy or changes in the Grouper program. Such a mechanism would also facilitate the earlier collection of specific data needed when payment or policy changes are considered or implemented.

The interim mechanism selected should be significantly different from the ICD-9-CM format and codes to avoid confusion both while the interim mechanism is in use and again after a permanent ICD-9-CM code is assigned. It is anticipated that interim mechanisms would be utilized only until appropriate permanent ICD-9-CM codes could be established.

DRG Classification and Weighting Factors

Recommendation 24: Adjustment of the Labor Portion of the Standardized Amounts for Some DRGs Involving Expensive Devices

The labor and nonlabor portions of the standardized amounts should be redefined for DRGs 39, 104, 105, 209, 471, and the newly defined DRGs for pacemaker implantation and replacement (Recommendations 25 and 26), implantable defibrillators (Recommendation 27), and penile prostheses (Recommendation 28). The new portions should more closely reflect the labor-related and nonlabor-related shares of costs for cases in each of these DRGs. These recalculations should be made so that total hospital payments remain unchanged.

The correct labor and nonlabor portions of the standardized amounts should be calculated from data currently being generated in the HCFA study of the labor portion of costs by DRG. If this information proves to be incomplete, the portions should be calculated from available cost and charge data for these DRGs. The Secretary should study the need for adjustments to the labor and nonlabor portions of the standardized amounts in all DRGs.

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PPS currently adjusts individual hospital payments to reflect differences in area wage rates. This adjustment is applied equally to all cases in all DRGs and is based on labor-related costs of approximately 80 percent in the average discharge.

Hospital cases involving expensive devices are atypical. The devices are usually sold in a national market, resulting—in these cases—in a higher proportion of costs that are unrelated to local wage rates. Hospitals in high wage rate areas therefore receive a significantly higher payment, relative to cost, for cases in these DRGs when compared to hospitals with lower wage rates. ProPAC has studied this payment inequity in the 36 DRGs with the greatest number of cases involving expensive devices. The financial effect is most significant in DRGs with the highest proportion of cases involving expensive devices and with a ratio of supply costs to total costs of approximately 20 percent or more. These include DRGs 39, 104, 105, 209, 471, and the newly defined DRGs for cases involving pacemaker implantation and replacement (Recommendations 25 and 26), implantable defibrillators (Recommendation 27), and penile prostheses (Recommendation 28).

The payment inequity can be corrected if the labor and nonlabor portions of the standardized amounts are redefined for each of the DRGs mentioned above. It is important, however, that this change not affect total hospital payments. Therefore, after all DRG weights are recalibrated in a standard manner, the weights for the device DRGs should be recalculated (using the new labor-related portion for standardizing charges). This recalculation would offset the effect of changing the labor and nonlabor portions of the standardized amounts.

The new labor and nonlabor portions of the standardized amounts should be calculated from data currently being developed in HCFA's study of the labor portion of costs by DRG. If this new information is incomplete or unavailable in time for this recommendation to be implemented, the portions of the standardized amounts should be calculated from available cost and charge data. ProPAC will furnish the Secretary with the information it used to develop this recommendation.

Although the inequities of the area wage index adjustment are most important in cases involving expensive devices, there may be a similar problem in many more DRGs. In addition, the average labor-related share of costs for all discharges, which HCFA estimates at roughly 80 percent, may have changed significantly with declining length of stay and hospital responsiveness to PPS incentives. The Secretary should, therefore, complete the congressionally mandated analysis of the impact of the area wage index adjustment as soon as possible, ensuring that these issues are thoroughly addressed. For more information on this recommendation, see Technical Appendix B.

Recommendation 25: Reclassification of Pacemaker Cases Based on Type of Device

Prior to recalibration, the DRGs involving implantation of cardiac pacemakers (currently DRGs 115 through 118) should each be restructured into two DRGs, one for cases involving dual-chamber or functionally similar pacemakers, and one for cases receiving other single-chamber pacemakers. New ICD-9-CM procedure codes should be created to distinguish between these types of cases. A mechanism should be established to evaluate the appropriateness of all implants involving dual-chamber or functionally similar pacemakers. In the initial year of this new classification, the weights for all pacemaker DRGs should be calculated using charge data from the PATBILL file and data on cost differences between pacemaker types.

Under PPS, a hospital receives the same DRG payment regardless of the type or model of pacemaker implanted. The implantation of a dual-chamber cardiac pacemaker, however, differs significantly from the implantation of a single-chamber model in at least two ways. First, use of a dual-chamber model leads to greater hospital costs. This difference in costs is due to a number of factors, including the cost of the device, the need for a second cardiac lead, and the longer operative time required for implantation. The Commission estimates that in 1984 a dual-chamber pacemaker and the extra lead cost an additional $1,736 over single-chamber implants.

Second, some patients requiring dual-chamber pacemakers are clinically distinct from other pacemaker patients. Although expert physicians differ in their judgments about certain indications

for dual-chamber pacing, there are some universally accepted criteria. The patients meeting these criteria are therefore clinically distinct from other pacemaker patients. To retain the clinical coherence of the pacemaker DRGs, cases involving dual-chamber pacemakers should be classified into separate DRGs.

The Commission would have preferred to recommend a revised classification based on patient characteristics rather than on the therapy provided. Unfortunately, the accepted criteria for implantation of dual-chamber pacemakers cannot all be described with specific diagnostic labels. Therefore, until such diagnoses and related codes are identified, classification must be based on the type of pacemaker implanted. Although current ICD-9-CM codes are inadequate to distinguish between types of pacemaker models, new codes should be developed in time for implementation of this recommendation by October 1, 1986.

The Commission recognizes that this recommendation will likely lead to increased use of dual-chamber pacemakers. Failure to reclassify pacemaker discharges based on type of device, however, could result in limiting the access of Medicare beneficiaries to this important technology. The Secretary can restrain the inappropriate use of the more expensive pacemakers by developing a mechanism to evaluate all implants involving dual-chamber or functionally similar pacemakers. In addition, ProPAC plans to follow closely the issues surrounding cardiac pacing and especially the further refinement of clinical criteria for implantation of different types of pacemakers. The Commission will review the subject completely within the next three years as necessary.

The Commission understands that some single-chamber pacemaker models now undergoing clinical investigation may be functionally similar to dual-chamber pacemakers. That is, in some cases, these new single-chamber pacemakers could substitute for the more expensive dual-chamber models. Because ProPAC does not wish to inhibit the development of such alternative technologies, the Secretary should consider classifying new pacemaker models into DRGs based on both device function and cost.

Since current ICD-9-CM codes are inadequate to distinguish among pacemaker models, calculation of the initial weights for these new pacemaker DRGs cannot be based entirely on currently existing Medicare data bases. During the first year this policy is in effect, the Secretary should calculate weights based on relative charges or costs in the pacemaker DRGs and the difference between dual-chamber and single-chamber implants, which ProPAC estimates to be about $1,740. For more information on this recommendation, see Technical Appendix B.

Recommendation 26: Reclassification of Pacemaker Replacement Cases

Prior to recalibration, the cases involving replacement of a permanent cardiac pacemaker, except those with myocardial infarction, congestive heart failure or shock, should be reassigned to DRGs that include only pacemaker replacements.

Data from the 1984 PATBILL indicate that, on average, cases involving pacemaker replacement use fewer hospital resources than cases undergoing initial implant, but more resources than cases involving revision without replacement. The only exception to this finding is for patients with myocardial infarction, congestive heart failure, or shock. The costs of pacemaker replacement for these patients are similar to the costs of initial implantation.

Despite these important distinctions, the Grouper program is not consistent in classifying these replacement discharges. A case with pulse generator replacement only (i.e., no change in pacemaker leads) is generally classified into DRG 118, and a replacement that also involves a lead change is generally classified into DRG 117. Either kind of replacement, however, can be grouped into the higher-paying DRG 116 if the hospital uses certain ICD-9-CM procedure codes. Finally, any pacemaker case (initial implant or replacement) in a patient with congestive heart failure, myocardial infarction, or shock is classified into DRG 115.

This inconsistency in classification of pacemaker replacements has led to substantial pay-

ment inequities across hospitals. One hospital, for example, may be paid significantly more for a case than another hospital providing a similar patient with a similar service. The Commission strongly believes that this error should be corrected. The Secretary should develop specific coding guidelines for cases involving replacement and change the Grouper program to classify these cases into distinct DRGs.

It is important, however, that these changes be combined with those proposed in Recommendation 25. There is significant variability in the resources used in replacement cases. Patients can have a single-chamber model replaced with another single-chamber model, a dual-chamber model replaced with another dual-chamber model, or a single-chamber model replaced with a dual-chamber model and its additional cardiac lead. This variation among replacement cases can most appropriately be reduced by classifying DRGs based on pacemaker type.

Recommendations 25 and 26, combined, lead to seven newly defined DRGs for pacemakers. They are summarized below. For more information on this recommendation, see Technical Appendix B.

Description of the Proposed New Pacemaker DRGs Based on Recommendations 25 and 26

- Initial implantation or replacement of a dual-chamber or functionally similar cardiac pacemaker in a patient with myocardial infarction, congestive heart failure, or shock.
- Initial implantation or replacement of other cardiac pacemaker in a patient with myocardial infarction, congestive heart failure, or shock.
- Initial implantation of a dual-chamber or functionally similar cardiac pacemaker in a patient without myocardial infarction, congestive heart failure, or shock.
- Initial implantation of other cardiac pacemaker in a patient without myocardial infarction, congestive heart failure, or shock.
- Replacement of cardiac pacemaker with a dual-chamber or functionally similar cardiac pacemaker in a patient without myocardial infarction, congestive heart failure, or shock.
- Replacement of cardiac pacemaker with other cardiac pacemaker in a patient without myocardial infarction, congestive heart failure, or shock.
- Permanent cardiac pacemaker system revision except replacement.

Recommendation 27: Implantable Defibrillator

Implantable defibrillator cases should be assigned to a unique DRG. The labor and nonlabor portions of the standardized amounts should be redefined for this new DRG to reflect the labor-related and nonlabor-related shares of costs for these cases.

The implantable defibrillator is a new medical device used in the treatment of some life-threatening ventricular arrhythmias. Discharges involving the implantation of this device are now a covered Medicare service and have been assigned to DRG 104 (cardiac valve procedure with pump and with cardiac catheterization).

The Commission believes that implantable defibrillator cases should be assigned to a unique DRG. The diagnoses and procedures for these cases are unlike those of discharges in other DRGs. More importantly, the costs of the defibrillator cases are themselves unique: more than 50 percent of the total costs are due to the device. To avoid significant payment inequities across hospitals in such cases, the labor and nonlabor portions of the standardized amounts should be redefined to reflect the labor-related and nonlabor-related shares of costs (see Recommendation 24). This can be accomplished only if the defibrillator cases are assigned to a unique DRG. The weight for the DRG should be calculated from available data so that hospital payments approximate costs.

The implantable defibrillator is a new technology that is undergoing rapid change. As the device becomes more widely used, additional adjustments to DRG classification may be required for cases involving percutaneous implantation of the device and lead, replacement of a device, or the revision or removal of an existing device or

lead. It will be important that new ICD-9-CM codes currently under consideration allow differentiation and monitoring of these cases. For more information on this recommendation, see Technical Appendix B.

Recommendation 28: Penile Prostheses

Prior to recalibration, cases involving the implantation of a penile prosthesis should be removed from DRG 341 and reassigned to a unique DRG. The labor and nonlabor portions of the standardized amounts should be redefined for this new DRG to reflect the labor-related and nonlabor-related shares of costs for these cases.

The cases in DRG 341 (penis procedures) involving implantation of a penile prosthesis should be reclassified into a unique DRG for several reasons. First, as currently defined, DRG 341 is not clinically coherent. Although all the patients undergo an operation related to the penis, many of the procedures are quite distinct from one another and are performed for markedly different medical indications.

Second, penile prosthesis cases utilize significantly greater hospital resources than other cases in the same DRG. The difference in charges, estimated from the 1984 PATBILL at about 35 percent, is due largely to the cost of the prosthesis. Such a large difference was probably not recognized during the development of the DRGs. Hospital resources were originally measured using length of stay whereas these cases have high costs despite short lengths of stay.

Third, as discussed in detail under Recommendation 24, the high nonlabor costs in the prosthesis cases result in payment inequities across hospitals. To avoid these inequities, cases with expensive devices should not be classified with non-device cases. In addition, the labor and nonlabor portions of the standardized amounts should be redefined to reflect the high nonlabor costs of the device. For more information on this recommendation, see Technical Appendix B.

Recommendation 29: Additional Payment for Magnetic Resonance Imaging

For a period of three years, Medicare should pay hospitals an additional amount (hereafter termed an add-on) for each covered magnetic resonance imaging (MRI) scan performed on an inpatient Medicare beneficiary in a PPS hospital. Under existing capital payment policy, the add-on for fiscal year 1987 should be $124 for each scan performed on beneficiaries in institutions where Medicare pays for the capital costs of an MRI scanner and $282 for each scan performed on beneficiaries in other PPS hospitals. In fiscal year 1988 and fiscal year 1989, the add-on amounts for all hospitals should be recalculated to reflect any change in the average cost of an efficiently produced scan and any changes in capital payment policy.

Magnetic resonance imaging is an important new diagnostic technology that has been approved for marketing by the Food and Drug Administration (FDA) for imaging the internal structure of the head and body. It has proven efficacy in a number of medical conditions and has tremendous potential for use in many more areas.

ProPAC believes that an alternative payment mechanism is necessary for MRI for several reasons. First, although MRI has recently become a covered service for most indications in Medicare beneficiaries, hospital payments have not been increased to reflect the additional costs of using the technology.

Second, while the increased costs of new technologies such as MRI will automatically be reflected in the DRG weights in subsequent years through recalibration, this process will also increase payments for cases in which no MRI scan is performed. Since MRI scanners are currently available to only a small number of hospitals, this averaging effect will tend to underpay hospitals utilizing MRI and overpay those not using the technology. This inequity may discourage hospitals from providing MRI scans.

Finally, ProPAC is concerned that the incentives inherent in current payment policy may result in an inappropriate distribution of MRI scanners. Approximately 50 percent of the scanners in this country are located outside of hospitals in a variety of outpatient settings. This distribution is atypical of most expensive medical technologies and has likely occurred due to a number of factors. These include delays in coverage by many third-party payers, certificate-of-need requirements, the incentives under PPS, and characteristics of the technology itself.

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The recent Medicare decisions to cover MRI scanning, reimbursing for each outpatient scan but not increasing inpatient payments, may inappropriately encourage scanning to be performed on an outpatient basis. Under current policy, these outpatient scans are reimbursed through Medicare Part B, with the beneficiary responsible for a 20 percent copayment. ProPAC believes that an additional payment for inpatient MRI scans will encourage hospitals to perform the scan as part of an inpatient hospital stay when it is more appropriate to do so.

The add-on would be paid to the hospital where the beneficiary is an inpatient. This policy encourages the hospital to provide scans in the most cost-effective manner. The proposed add-on amounts are estimates of the average cost of a scan at an efficiently run facility, adjusted for the degree to which MRI may substitute for other hospital resources. The Commission believes that the amount of the add-on should not bias a hospital's decision about whether to purchase an MRI scanner or to obtain scanning services from another provider. Thus, since institutions that own scanners receive an additional payment for the capital related costs of MRI, a higher add-on amount is provided for hospitals that do not own scanners.

With this approach, the total payment per scan for both types of institutions would include capital as well as operating costs. Furthermore, the add-on to either type of hospital should be adjusted over the next three years to reflect changes in the average costs of efficient scanning and any changes in capital payment policy. At the end of three years, the Commission will reevaluate the adequacy of PPS payments for MRI and the need for continuing an add-on.

In Recommendation 5, ProPAC proposes that the Secretary initiate a transition to all-inclusive prospective prices that combine operating and capital cost components in a single prospective payment per case. The exact timing and nature of any future changes in capital payment policy are not yet clear, however. If capital has not been included in PPS within three years, the Commission will consider the desirability of a single add-on payment for all hospitals and the exclusion of cost-based capital payments for MRI.

The Commission strongly believes that this add-on payment should not lead to an increase in total Medicare payments beyond that calculated for the scientific and technological advancement component of the discretionary adjustment factor (Recommendation 2). Targeted payment adjustments of this type should be offset in the DAF so that the total amount allowed remains unchanged by the add-on payment. When the appropriate data become available, the Commission will also recommend adjustments in DRG weights to account for the add-on. This should not be a significant problem in the interim, however, because MRI scans are performed in relatively few cases.

ProPAC recognizes that this recommendation departs from the concept of a single payment per discharge regardless of the resources used during the admission. The importance of MRI, however, and the potentially serious consequences of not providing the appropriate financial incentives for this technology have led the Commission to its decision. For more information on this recommendation, see Technical Appendix B.

Recommendation 30: Extracorporeal Shock Wave Lithotripsy

Prior to recalibration, cases in which extracorporeal shock wave lithotripsy (ESWL) is the principal procedure should temporarily be removed from DRG 324 and reassigned to DRG 323. The payments and costs for all cases in this DRG should be monitored to determine the appropriateness of PPS payments for operating costs. A unique procedure code should be identified for ESWL.

Extracorporeal shock wave lithotripsy is a new, noninvasive technology that uses shock waves to remove urinary tract stones. When DRGs were initially developed, ESWL was not a covered service for Medicare beneficiaries. In 1985, ESWL was covered and the cases were assigned to the medical DRGs 323 (urinary stones, age >69 and/or CC) and 324 (urinary stones, age <70 w/o CC).

The Commission examined data on ESWL costs, charges, and utilization rates from many different sources and concluded that payments for DRG 324 are inappropriately low. Payments for ESWL cases in DRG 323 more closely reflect operating costs. Neither clinical nor financial data were

found to justify splitting ESWL cases based on age, complications, or comorbidities. The newly defined DRGs could have the following proposed title changes:

DRG 323 Lithotripsy or urinary stones, age >69 and/or CC, and
DRG 324 Urinary stones, age <70 w/o CC, w/o lithotripsy.

While classification in DRG 323 results in the most appropriate payments for these cases, the average cost of treating a patient with ESWL is extremely sensitive to the number of procedures performed. The cost data used in the ProPAC analysis reflect, on average, a relatively low volume of cases in institutions with lithotripters. As hospitals utilize their equipment more efficiently, costs per case are likely to decrease. The Commission, therefore, recommends continued monitoring of ESWL procedure costs and other routine and ancillary hospital service charges over the next year.

ESWL does not have a unique ICD-9-CM procedure code. Cases involving ESWL are distinguished from cases undergoing other kinds of lithotripsy by combinations of two procedure codes. The Commission recommends establishing a unique code for ESWL so that these procedures can be monitored more accurately in the future. For more information on this recommendation, see Technical Appendix B.

Recommendation 31: Lymphomas and Leukemias

Prior to recalibration, cases currently assigned to DRGs involving lymphoma, leukemia, and other related diagnoses (DRGs 400-404) should be reclassified into one of five newly defined DRGs. The new classification should provide a unique DRG for acute leukemia cases not involving a major operative procedure, eliminate age as a criterion for DRG assignment, and modify present classification based on operative procedure, complications and comorbidity. Other ways of further improving these DRGs should continue to be explored.

The current lymphoma/leukemia DRGs (400-404) are very heterogeneous in terms of resource consumption. This is evident not only from public comment but also from high coefficients of variation obtained when studying charges and costs.

Alternative ways of grouping these cases have been considered in depth. Principal diagnosis, age, major and other operating room procedures, complications/comorbidity, and discharge status have been studied. Based on a number of considerations, including the intent and design of PPS and the amount of within-DRG heterogeneity that can be reduced, the Commission believes lymphoma and leukemia patients should be classified into the following groups:

DRG 400 Lymphoma/leukemia with major operating room procedure,
DRG 401 Acute leukemia without major operating room procedure,
DRG 402 Lymphoma/non-acute leukemia with other operating room procedure and complication/comorbidity,
DRG 403 Lymphoma/non-acute leukemia with other operating room procedure or complication/comorbidity, and
DRG 404 Lymphoma/non-acute leukemia without operating room procedure or complication/comorbidity.

The proposed DRGs would be an improvement over the current DRG classification in reducing heterogeneity. Cases in these DRGs should be monitored to determine if additional adjustments will be necessary. Other methods for improving these DRGs should continue to be studied. For more information on this recommendation, see Technical Appendix B.

Recommendation 32: Upper Extremity Procedures

Prior to recalibration, cases involving procedures of the upper extremity that are currently classified in DRGs 223, 224, 228, and 229 should be reassigned based on anatomical location and the presence of systemic collagen vascular disease or implantation of joint prostheses or complications and/or comorbidities. Nonsurgical hip fracture cases currently being assigned to DRGs 223, 224, 225, 228, and 229 should be reassigned to the appropriate medical DRG.

The current classification of cases in DRGs 223, 224, 228, and 229 fails to distinguish adequately between groups of cases with markedly different resource use according to meaningful clinical criteria.

The Commission studied many alternative groupings of these cases, using combinations of selected principal diagnoses, specific procedures, age, and complications. Based on a number of considerations, including the intent and design of PPS and the amount of within-DRG heterogeneity that can be reduced, the Commission believes patients with upper extremity procedures should be reclassified into the following groups:

DRG 223 Upper extremity procedure except humerus and hand; with joint prosthesis or complications and/or comorbidities,
DRG 224 Upper extremity procedure except humerus and hand; w/o joint prosthesis or complications and/or comorbidities,
DRG 228 Hand procedure; with joint prosthesis or collagen vascular disease or complications and/or comorbidities, and
DRG 229 Hand procedure; w/o joint prosthesis or collagen vascular disease or complications and/or comorbidities.

Currently, patients with the principal diagnosis of hip fracture who are treated medically but who also undergo a procedure on the upper extremity or foot are classified into DRGs 223, 224, 225, 228, or 229 based upon the procedure. The Grouper should be changed to assign these cases to the appropriate DRG for nonsurgical hip fractures. For more information on this recommendation, see Technical Appendix B.

Data Development and Research

Recommendation 33: Maintaining a Commitment to Data Development and Research on PPS

The Secretary should continue to devote substantial resources to data development and research for monitoring and improving PPS and understanding its effects on the health care system. Studies mandated by the Congress that are already due should be completed and made public as soon as possible, and new studies that analyze more recent data should be designed and implemented as soon as possible. While ProPAC and other organizations will participate in this process, the major commitment to PPS data development and research must reside in the Department of Health and Human Services.

For the foreseeable future, continued data development and research should be viewed as an intrinsic part of PPS. While new policy directions may require major investments in data collection and analysis, such investments should not displace needed further data development and research on PPS.

The Commission has identified a number of areas in which current data and analysis are sorely needed both for understanding the consequences of PPS and for the development of solutions to problems. A prime example is to determine the effects of PPS on the quality of care received by Medicare beneficiaries. Most of the research to date has been done with data that includes only a short period of time corresponding to hospital payment under PPS. Moreover, because the transition to Federal payments under PPS is incomplete, data collection and research must continue until the full effect of a completely phased-in system can be assessed.

It would be contrary to Medicare beneficiaries' interests to reduce the commitment to understanding PPS at a time when the potential for achieving this understanding is increasing. The Commission will continue to devote its resources to data development and research on PPS issues. It welcomes the opportunity to work with the Secretary on plans for the HHS agenda. The Commission will continue to make public the results of its research and hopes that the Secretary will also continue to share the results of HHS research.

Chapter 3

Analytic Plans for Improving the Prospective Payment System

This chapter summarizes the Commission's immediate and long-term analytic plans to improve the prospective payment system. These plans reflect a continuation and expansion of the studies supporting the recommendations presented in Chapter 2.

Improving and updating PPS are essential to make prospective payment an equitable system that enables hospitals to continue to deliver high-quality care in a cost-effective manner. Thus, through its analytic agenda, the Commission will identify and analyze problems and recommend improvements in current methods of DRG classification, case-mix measurement, and calculation of payment amounts. These improvements are necessary to ensure equitable payments to hospitals and to reflect changes in medical technology and practice patterns.

In some cases, the recommendations made this year called for temporary adjustments. Although it would have been desirable to propose permanent adjustments, the lack of current data as well as changes in medical practice since PPS implementation prevented this. The Commission intends to continue to monitor changes in medical practice and to collect and analyze additional data in order to recommend more permanent adjustments in the future.

The delivery of high-quality care in a cost-effective manner is one of ProPAC's chief priorities. While the Commission believes that implementation of PPS has so far been successful, some incidents have been reported that require particular attention to monitoring and measuring quality of care. The thrust of much of ProPAC's analytic work is designed to study this key area.

The first section of this chapter describes analyses aimed at improving DRG classification and case-mix measurement. Some of the issues discussed in this section emerge as cross-cutting problems between case-mix measurement and the establishment of payment amounts. The second section discusses methods to improve and update the payment amounts. The final section presents an overview of the Commission's strategy for research related specifically to quality of care and other beneficiary concerns.

IMPROVING DRG CLASSIFICATION AND CASE-MIX MEASUREMENT

In the April 1985 report, the Commission outlined problems related to the DRG patient classification system as it is used to measure hospital case mix. Three broad approaches for improving case-mix measurement were suggested:

- Retaining the current system but revising it incrementally as problems emerge,
- Retaining the system in principle but reconstructing it using newer, more complete data bases, and
- Considering an alternative system, either in conjunction with DRGs or to replace DRGs.

Based on the work undertaken since the April 1985 report, ProPAC has recommended retaining the current DRG system for the present along with making several incremental modifications and improvements to the system. The analyses completed by the Commission and others, however, have demonstrated that resource use varies considerably within some DRGs. The causes of the variations are complex and need to be better understood before recommending a major restructuring of the DRGs. To this end, the Commission has developed an analytic plan for systematically evaluating the heterogeneity of the DRGs. This evaluation will provide empirical evidence for

evaluating the principles of case-mix measurement.

Because of substantial differences in case complexity observed within individual DRGs, alternative case-mix measurement systems—especially those focusing on severity-of-illness measures—have gained considerable attention as a possible method for improving or replacing DRGs. While understanding of the complexities and deficiencies of the current system is increasing, much remains to be learned about the advantages and disadvantages of alternative systems. Currently, generally accepted criteria for evaluating these systems are nonexistent. Further, a comprehensive, comparative evaluation of DRGs as well as alternative case-mix systems has not yet been performed.

The Commission's analytic plans to improve the measurement of case mix will continue to follow the same approaches mentioned above. The major study areas are summarized here and discussed more fully in the rest of this section.

- Analysis and evaluation of new and changing technologies and practice patterns will continue. Incremental improvements to the current DRGs will be developed that reflect the results of these studies.
- The current studies of heterogeneity and case complexity for specific DRGs and groups of DRGs will continue. Further studies will expand the scope to a broader examination of all DRGs. Specifically, these studies will examine the adequacy and appropriateness of existing and alternative DRG assignment criteria. They will be designed to identify areas to improve DRG homogeneity and better account for case complexity and severity of illness.
- The analyses of specific DRGs and groups of DRGs have pointed to additional topics that will require further study. These topics relate to the measurement of case mix as well as the calculation of the payment amounts and include:
  - —Outlier payment policy,
  - —Geographic variations in resource use,
  - —High device costs and the labor/nonlabor portions of the payment amounts,
  - —Allocation of nursing costs, and
  - —Transfers and readmissions.
- Monitoring the development and comparative evaluation of alternative case-mix measurement systems will continue.

Technologies and Practice Patterns

The Commission and many others have been concerned about the need to incorporate new technologies and medical advances into the system. Part of ProPAC's resources have been and will be devoted to recommending appropriate adjustments in DRG classifications and weights in order to incorporate new technologies as they become Medicare-covered services. The Commission will also examine the need for adjustments to reflect changes in the use of existing technologies or changes in practice patterns. It will recommend improvements on an incremental basis when necessary.

The Commission is pleased that the Secretary has implemented procedures for making changes to the DRG classifications. Under these procedures, most changes will be made when annual PPS regulations are promulgated. Some new technologies will become covered services at other times, however, and the Commission will consult with HCFA on issues related to DRG assignment as these technologies are covered by Medicare.

Incorporating new technologies and practices into PPS may be difficult. The Commission recognizes that there are unique problems for new technologies that are expensive but enhance quality of care. The Commission is concerned about the mechanisms for providing timely and appropriate payments (e.g., recalibration and reclassification). These mechanisms may not always provide the appropriate incentives for the development, adoption, and diffusion of new technologies. Likewise, the Commission wishes to avoid financial incentives that result in the adoption of technologies that are unproven or unnecessary for the efficient delivery of high quality care.

Based on its evaluation of two new and costly technologies, ESWL and MRI, the Commission recommended two very different adjustments to the system: a reclassification of patients undergoing ESWL and an add-on payment for patients undergoing MRI scanning. The Commission will continue to address the special problems associated with costly new medical technologies on a case-by-case basis, recognizing that solutions may vary significantly depending on the technology.

The Commission will focus on improvements using existing payment policies, such as reweighting or "pricing" of certain DRGs. It is likely, as is the case for ESWL and MRI, that adjustments will be recommended on a temporary basis or for an interim period. This will permit the development of better data bases for accurately measuring costs and efficiency changes as technologies diffuse. ProPAC will continue monitoring these technologies as they are incorporated in medical practice.

While the financial incentives under PPS may adversely affect the development, adoption, and diffusion of costly new technologies, the objective evidence available to document such effects is limited. The Commission will monitor studies being conducted by other organizations and consider implementing a study to evaluate the effects of PPS in this area.

Improvements in the DRG system to incorporate changes in medical technologies and practice patterns, as well as general improvements in DRG homogeneity, must be achieved within the constraints of the current ICD-9-CM coding system for procedures and diagnoses. For some technologies or practices, new codes will need to be developed. In other instances, administrative mechanisms to identify specific procedures or conditions in the absence of an appropriate code will need to be devised. The Commission has made several recommendations this year regarding maintenance and updates to the ICD-9-CM system for payment purposes. ProPAC will continue to monitor changes in the coding system, recommending improvements that are necessary to keep the system up to date.

The availability of data bases for accurately pricing new technologies and services is a critical need for determining appropriate weights for new technologies. Typically, manufacturers are the only sources of data. These data bases provide limited information. The Commission has found it necessary in some cases, such as ESWL, to make temporary recommendations while monitoring the use of the technology and gathering additional data. In other cases, such as burn DRGs, the Commission has withheld recommendations until better data become available. ProPAC will continue to monitor the development of data for these technologies and use new data sources as they become available.

Heterogeneity

The Commission has identified significant heterogeneity problems in the DRG system as a result of its examination of classification problems for specific DRGs or groups of DRGs. Heterogeneity is a source of concern because of its association with payment inequities. (Heterogeneity is defined as the degree of dissimilarity among cases within a patient category.) These case-by-case analyses, prompted by concerns that case complexity varies widely within certain DRGs, have led the Commission to recommend structural changes in some DRGs. These include DRGs for lymphomas and leukemias, as well as DRGs involving upper extremity procedures. These case examples of heterogeneity reflect the inability of DRGs to capture differences in case complexity that may be due to: inadequate measures of complications and/or comorbidities; lack of specificity in operating room procedures performed; or other underlying problems with the DRG assignment criteria.

ProPAC will continue to examine the causes of heterogeneity and to develop recommendations for improvements to the DRG system on two levels. On a general level, the DRGs will be systematically evaluated to determine the global changes in the DRG assignment criteria necessary to increase the homogeneity of the DRG system. The Commission will also continue to study individual DRGs or groups of DRGs on a case-by-case basis and recommend improvements. In its efforts to improve the DRG system, the Commission will focus on the following heterogeneity issues.

DRG Assignment Criteria

The analyses completed to date have provided evidence of variation in case complexity within DRGs. Much of this variation can be linked to inadequacies in the underlying principles, or assignment criteria, of the DRG system.

Complications and/or Comorbidities.—The use of complications and/or comorbidities (CCs)—particularly the sequence or combination of one or more diagnoses—needs to be carefully reviewed. Currently, one list of complications and/or comorbidities applies to all DRGs. These are not specific to DRGs or Major Diagnostic Categories (MDCs). Payment may not reflect the resources required to treat specific complications and/or comorbidities. Preliminary evidence from ProPAC analyses suggests that modifying the use of complications and/or comorbidities in DRG assignment may reduce heterogeneity within some DRGs. Creating DRG- or MDC-specific lists on the basis of resource intensity is a possible approach to DRG improvement.

Patient Age.—Patient age is used in a number of DRGs for assignment. As an assignment criterion, age is typically used in conjunction with the presence of a complication and/or comorbidity (e.g., "Age >69 and/or CC"). Some researchers have argued that to reduce DRG heterogeneity, other age splits may be more appropriate to identify older patients (e.g., persons who are at least 80 years of age), who are presumably sicker. Preliminary analyses of heterogeneity within DRGs indicate that age is probably less important than the presence of complications and/or comorbidities. Additional work is necessary to determine the validity of this finding for all DRGs and the appropriateness of combining the age criterion with the presence of complications and/or comorbidities. Moreover, if revised lists are developed, age splits may not be necessary.

Operating Room Procedures.—The list of operating room procedures and surgical hierarchies within MDCs should also be reviewed. Currently, cases are assigned to DRGs on the basis of the presence or absence of an operating room procedure within MDCs. ProPAC analyses (e.g., for DRGs involving upper extremity procedures) have suggested that heterogeneity can be reduced by further separating patients on the basis of specific operating room procedures.

Patient Disposition at Discharge.—Relatively few DRGs are defined on the basis of patient disposition at discharge. For example, only a few DRGs use death in the assignment criteria. Preliminary analyses of a sample of DRGs confirm that, on average, costs incurred in the care of patients who die in the hospital are much greater than costs incurred in the care of patients in the same DRG who do not die. Furthermore, for some DRGs (e.g., burn DRGs) patients who died were concentrated in certain types of hospitals. The inclusion of discharge disposition could be used more extensively as an assignment criterion if the severity of patients who die is not adequately measured using the current classification variables.

Other Assignment Criteria.—Other problems with the current assignment criteria for DRGs include the determination of principal diagnosis, the presence of multiple diseases during the same admission, and the definition of DRG 468 (operating room procedure unrelated to principal diagnosis). ProPAC will continue to consider changes in these areas that may improve homogeneity within DRGs.

Other Case-Mix Measurement Issues

In addition to the topics discussed above, the Commission's continuing efforts to improve the measurement of case mix will focus on several general issues that are also related to the determination of the payment amounts. These issues are discussed below.

Outlier Payment Policy

Analyses of specific DRGs (e.g., burn DRGs) have identified considerable differences in outlier rates among hospitals. These findings were supported by statistics for a broad range of DRGs, where outlier rates varied significantly across DRGs and by type of hospital within DRG. Differences in outlier rates across institutions may occur for various reasons. These include severity-of-illness differences not currently measured by the DRG system; hospital or physician inefficien-

cies, or both; or other problems in case-mix measurement, such as ICD-9-CM coding limitations.

Thus, the Commission believes that changes in the payment mechanism for outlier cases may be an important method for addressing the problems of heterogeneity. This may be true, for instance, for DRGs where the severity of illness for outlier patients is not adequately measured by the current system. It may be appropriate to adjust the outlier payment rates to more accurately account for the additional costs of treating these patients beyond outlier thresholds.

While changes in outlier payment policy will not make the DRGs more homogeneous, modifying the payment mechanism for outliers may limit the need for improving DRG homogeneity to only inlier cases. ("Inlier cases" are all cases that are not in the outlier category.) That is, the combination of homogeneous DRGs for *inlier* cases and adequate payment mechanisms for *outliers* may solve the inequity problems caused by heterogeneous DRGs. The Commission will continue to examine outlier cases in its analysis of DRG heterogeneity and to consider appropriate changes to outlier payment policies, including marginal payment rates and the outlier thresholds.

Geographic Variations in Resource Use

Geographic variations in resource use are another important source of heterogeneity within DRGs. During 1985, the Commission began examining the extent of geographic variations within DRGs using the existing Medicare data bases. In future analyses, ProPAC will attempt to determine the amount of geographic variations resulting from differences in severity or complexity that the DRG system does not capture adequately.

Documenting and understanding the sources of geographic variations in resource use are also important considerations for many of the other issues facing the Commission. Geographic variations must be considered when new and changing technologies or practice patterns are incorporated into the system. These variations are also important in the analyses of hospital efficiency and productivity to support the empirical basis for the DAF, and in the analysis of changes in the hospital product. Further, studies related to quality of care and the impact of PPS must also take geographic variations into account. The Commission will continue its efforts to document the extent and causes of geographic variations.

High Device Costs and the Labor/Nonlabor Portions of the Payment Amounts

In its 1985 report on the appropriateness of hospital payments for pacemaker implantation, the Commission identified several problems due to the high cost of pacemaker units and unique cost structure of hospital discharges involving pacemaker implantation. Subsequent analyses revealed similar problems with other expensive implantable devices including intraocular lenses, cochlear implants, penile prostheses, and artificial urinary sphincters. Analysis of DRGs involving expensive devices led the Commission to make several recommendations this year.

The Commission has examined the atypical cost structure for discharges involving expensive devices. Adjustments to the labor and nonlabor portions of the standardized payment amounts have been recommended for several DRGs (e.g., cardiac pacemakers) as a result of this analysis. The current methodology for the payment mechanism and for DRG weight calculation assumes that roughly 80 percent of the cost is labor-related. Since this percentage is adjusted for local wage rates, large distortions in payments occur for DRGs where device (nonlabor) costs account for much more than 20 percent. The Commission will continue to study the appropriateness of the current 80/20 policy for labor and nonlabor costs across all DRGs and will recommend improvements where necessary.

Allocation of Nursing Costs

In making its recommendations for improvements in case-mix measurement, the Commission will consider the ability of the DRG system to promote appropriate levels of nursing services to maintain quality care. The Commission has previously expressed concern that the methods used to allocate nursing costs have produced significant inaccuracies in the DRG weights, possibly requiring adjustments to the DRGs to better meas-

ure nursing intensity. Further, the Commission believes that adjusting for nursing intensity may be a useful mechanism for improving DRG homogeneity. The accuracy of the payment amounts may also be improved by incorporating measures of nursing intensity and skill mix into the current costing mechanism.

The Commission has completed, through a contract with Health Economics Research, Inc., a comprehensive evaluation of existing nursing patient classification systems. This contract also provided a review of the literature regarding alternative costing methods for nursing services, the effects of PPS on the quality of nursing care, and the relationship between nursing intensity and patient severity of illness. ProPAC will use this information and results from preliminary empirical analyses in the development of its research strategy for addressing the nursing intensity issue. The Commission will also monitor the empirical research on the allocation of nursing costs funded by HCFA and incorporate those findings into its planned research.

Transfers and Readmissions

The Commission recognizes the responsibility of the PROs to review the transfer and readmission of patients as part of their overall review of medical practice under PPS. The Commission's concern regarding transfers and readmissions relates to the severity difference of patients who are transferred and the adequacy of payments for these patients. The adequacy of payments between the transferring and receiving hospitals and the incentives provided by transfer payment policy will be examined in the context of specific DRG analyses (e.g., burn DRGs) and as part of the Commission's overall analysis of case-mix measurement issues.

As outcome measures, changes in readmission and transfer rates (for the same conditions) may provide empirical evidence about how PPS affects the quality of patient care. The Commission will analyze Medicare data bases to document changes in transfer and readmission rates as hospitals continue to respond to PPS incentives.

Alternative Case-Mix Measurement Systems

As discussed above, the Commission believes that the DRG classification system should be retained, for the present, as the most appropriate measure of hospital case mix. The Commission recognizes that, in the long-term, it may be necessary to consider alternative case-mix measurement systems. This would be the case if the DRG system proves to be inadequate for incorporating new and changing technologies and practice patterns, or for measuring case complexity and severity of illness. The Commission has examined possible criteria for evaluating alternative case-mix measurement systems and will continue to examine these systems as they are developed and improved. If the DRG system is to be replaced or combined with an alternative system, ProPAC believes that an evaluation of the alternative system's against a uniform set of criteria using a single data base would be necessary.

IMPROVING AND UPDATING THE PAYMENT AMOUNTS

The Commission seeks improvement in current methods of DRG classification and case-mix measurement so that PPS payments are distributed in a manner consistent with variations in the resource requirements of treating patients. ProPAC's approach to improving case-mix measurement focuses on both methods for incorporating new technologies and changing practice patterns, and generic improvements in the system necessary to maintain quality care.

In addition to accurate distribution of payments, the Commission is concerned about whether the PPS payment levels are adequate to enable hospitals to provide high-quality care to Medicare beneficiaries. Adequate payments may not ensure that individual hospitals will maintain quality care. The Commission believes, however, that PPS should provide appropriate incentives and payments to encourage hospitals to provide high-quality care.

The standardized amounts are the foundation of PPS payments and a major focus of ProPAC's work. The Commission's efforts include identifying appropriate updates to the standardized amounts as well as considering the effects of recalculating the amounts using more recent data. Furthermore, the Commission plans to perform analyses of other payment issues related to the standardized amounts.

Updating the Standardized Amounts

ProPAC's mandate includes the development of recommendations regarding an appropriate annual percentage change in the standardized amounts. This change, referred to as the update factor, is comprised of a market basket adjustment (with corrections for forecast error) and the discretionary adjustment factor. The Commission's work to refine these components and to assess strategies for recalculating them are discussed below.

The Discretionary Adjustment Factor

The DAF is a quantitative factor that reflects the Commission's judgment of an appropriate allowance for changes in hospital productivity, site-of-care substitution, real case-mix change, and scientific and technological advances. The underlying purpose of the DAF is to ensure that, in combination with ProPAC's other recommendations, the Medicare program continues to provide adequate payments for high-quality hospital care that promotes long-term cost-effectiveness.

The Commission has devoted significant resources toward developing more precise measures of changes in hospital practice patterns. During 1986, it will continue refining the information used to determine the allowance. Furthermore, ProPAC will explore new data sources to enhance the foundation for the discretionary adjustment factor.

Many of the indicators used to determine the DAF are influenced by multiple, cross-cutting factors. Changes in case complexity, for example, may be due to scientific and technological advances that enable hospitals to treat a wider range of patients. For each DAF component, the Commission will attempt to develop more precise indicators that take into account the interrelationships among the components. In this way, ProPAC can more precisely relate trends in overall expenditure patterns with the individual allowances it establishes for each component.

The following section describes specific analytic activities planned by the Commission to support development of the DAF.

Productivity.—The Commission will expand its consideration of changes in productivity to include the use of *total* inputs. This will require assessing the role of labor, capital, and other nonlabor costs in changes in hospital productivity. In addition, the data used to measure productivity will be refined. Specifically, ProPAC will examine more accurate methods to derive costs from existing charge data.

Site-of-Care Substitution.—Measuring site-of-care substitution requires knowledge of the services provided outside the hospital setting to patients who are hospitalized. While data are available to measure resources consumed in the inpatient setting, little information is available on services provided out of the hospital. The Commission plans to explore improved data sources that reflect care provided to patients for an entire episode of illness. Efforts will focus on refining Medicare Part B data and linkage of Medicare Part A and Part B data, by beneficiary, for episodes of illness.

Real Case-Mix Change.—In addition to observed shifts in patients among DRGs, the resource consumption of patients within a DRG may be changing. The Commission will refine its measure of changes in patient complexity within DRGs and associated changes in resource consumption. Analyses will focus on distinguishing real case-mix changes from coding changes, the relationship between case complexity and resource requirements, and measurement of changes in resources consumed.

Scientific and Technological Advances.—The Commission will emphasize studies to estimate the costs associated with new technologies and the ability of the DAF to support the diffusion of these technologies. It will also explore the broader implications of changes in practice patterns on scientific and technological advances. Changes in the application of new technologies in patient care and

the cross-cutting effects of new practice patterns on resources consumed will be analyzed.

The Hospital Market Basket

The hospital market basket index reflects inflation in goods and services purchased by hospitals. It is constructed by determining the inputs that hospitals purchase, the relative weight of each input, the appropriate proxy to measure price changes of each input, and estimates of price changes. Developing the market basket index involves judgments about the appropriate components and price change measures. Often, trade-offs are made between the validity of the measurements and the availability of data.

Recognizing the judgments and trade-offs made in developing the market basket index, the Commission plans further study of possible refinements. In its April 1985 report, ProPAC stated its intent to study certain features of the hospital market basket used to update the PPS standardized amounts. The studies described below will be used in the Commission's deliberations during 1986.

The Number of Market Baskets.—This study will update earlier HCFA analyses of regional market baskets. Information on regional variation in hospital expenses and price differences will first be developed. Then comparisons will be made of regional market basket indexes with the national index.

Effects of the Minimum Wage Law.—Initially, a survey will be conducted to determine existing data sources for comparing the effects of changes in the Federal minimum wage law on hospital workers compared with workers in other industries. If appropriate data are available, the relative effects of changes in the minimum wage law on hospital workers will be analyzed.

Correction of Errors in Forecasting Hospital Wage Increases.—A review will be conducted to determine the extent to which industry-specific wage information is used by public utility commissions or other regulators to set prices in regulated industries. The study will include an analysis of the conditions under which hospital behavior, including hospital response to PPS incentives, could affect the forecasted increase in the market basket.

Measurement of Employee Benefits.—A study will be conducted on the treatment of employee benefits in the PPS market basket. This will include a comparison of the current measure of employee benefits and alternative measures, such as those used by state prospective payment programs.

Recalculating the Standardized Amounts

The Commission believes that, in updating the payment amounts, information reflecting the relationship between hospital costs and PPS payments would be valuable. The Commission has also stressed the importance of more recent cost data on which to make judgments about appropriate payment amounts. ProPAC will continue to monitor the efforts of HCFA to produce more timely cost data. In addition, the Commission plans to examine other issues related to recalculating the standardized amount, which are described below.

Alternative Methods for Recalculation.—The original standardized amounts were calculated giving each hospital the same weight; that is, "hospital-weighted" averages were calculated. The Commission has documented significant distributional shifts in PPS payments if "discharge-weighted" averages were computed instead, giving hospitals with a greater share of Medicare discharges more weight. The Commission will continue to study this issue to determine the most appropriate method of calculation and to further document the distributional effects of each method.

Sampling Hospital Cost Data.—The Commission, through a contract with the Rand Corporation, has completed a preliminary evaluation of HCFA's sample of unaudited cost report data for 1,200 hospitals for the first year of PPS. While Rand found the sample to be representative of those hospitals used to create the standardized amounts, future analyses will determine the precision of estimates generated from this sample. The Commission also plans to examine the feasibility of developing a sample of PPS cost reports from the subset of hospitals with accounting year-end dates earlier in the fiscal year.

Analysis of Cost Data for the First Year of PPS. —The Commission expects to soon receive from HCFA the Medicare Cost Report data for the first year of PPS. A complete set of unaudited reports and audited reports for the sample of 1,200 hospitals (mentioned above) are expected. ProPAC plans to use these data for a number of analyses:

- Recalculating the standardized amounts,
- Updating the comparison of DRG weights calculated by using only charges, with weights calculated by using charges adjusted by costs,
- Documenting changes in costs by cost center since 1981,
- Studying the causes of differences in hospital costs, and
- Analyzing capital costs.

Other Issues Related to the Payment Amounts

Besides updating the PPS payment amounts to reflect changes in the cost of providing care, the Commission recognizes that problems exist in the calculation of certain payment components. Additional complexities arise from failure to reflect capital costs in the payment mechanism. The Commission plans to address these issues through improved understanding of historical cost differences among hospitals and the nature of these costs. Efforts to address other payment amount issues are described in this section.

Hospital Labor Market Areas and Wage Indexes

The urban and rural Federal portion of PPS payment amounts are adjusted to reflect variations in hospital employee wages based on hospital labor market areas. The Commission is concerned about the deficiencies in the current hospital labor market areas. Specifically, ProPAC questions whether they adequately reflect hospital wage variations within urban areas (that is, inner-city versus suburban areas) and variations within the rural areas of a state.

The Commission is studying this issue and has obtained preliminary evidence to justify its concern. Analysis will continue in an effort to develop specific improvements. ProPAC will also study whether current labor and nonlabor proportions of the standardized amounts are appropriate. In addition, it will examine factors that measure the difference in skill mix of hospital employees.

Furthermore, the Commission will continue to monitor the results of HHS evaluations related to hospital labor market areas and will consider these results in formulating improved definitions. Specific recommendations on improved definitions of hospital labor market areas will be made by the Commission no later than April 1987, and possibly in time for the fiscal year 1987 rulemaking process.

The Hospital Product

Understanding changes in the hospital product is important in updating payment amounts, improving DRG classifications and weights, and determining the health outcomes of beneficiaries. The definition of the hospital product, however, is subject to wide interpretation. The product can be characterized as a DRG, the inpatient stay, an entire episode of illness, or patient health outcomes. The Commission will continue to study the nature of the hospital product in order to more precisely define and measure product changes in the future.

Changes in the hospital product may be the result of shifts in the treatment provided during the inpatient stay or shifts in the site of care. The measurement of these changes requires associating hospital costs with the products produced. The Commission plans to study the factors influencing changes in the hospital product as well as alternative costing methodologies. This effort will provide insight regarding needed refinements to PPS and the potential effect of future policy decisions on the production function of hospitals.

Excluded Hospitals

Hospitals excluded from PPS by statute include psychiatric, rehabilitation, pediatric, and long-term care facilities. HCFA and others have con-

ducted studies to determine the differences between PPS hospitals and excluded hospitals. Little of the information developed to date, however, can be used to determine an appropriate payment update for excluded hospitals. The types of patients seen and the treatment provided vary significantly between PPS hospitals and excluded hospitals. The data for excluded hospitals, however, are significantly limited.

During 1986, ProPAC will continue to refine the data used to make its recommendations regarding excluded hospitals. This will include the development of trend data relevant to the update factor. The Commission also intends to continue its study of excluded hospitals in an effort to understand the unique production function of these institutions. Emphasis will be placed on better understanding changes in case mix, productivity, and the impact of scientific and technological advances on the care these hospitals provide. In addition, ProPAC will focus on improving methods for distinguishing between excluded hospitals and excluded units and their products. Finally, the Commission will examine the implications for the DAF of incorporating capital payments into the target rate of increase limits established for excluded hospitals and distinct part units.

Rural Hospitals

The Commission believes that several PPS policies may adversely affect rural hospitals. Some of the policies apply solely to rural hospitals. Others affect all hospitals, yet may have a stronger impact on rural providers. ProPAC, therefore, will focus on differences between urban and rural hospitals in the study of issues mentioned previously, such as hospital labor market areas, DRG classification and case-mix measurement, outlier payments, DRGs with high device costs, and calculation of the standardized amounts. In addition, the Commission will continue efforts to identify problems related to the treatment of rural hospitals under PPS.

Beyond the efforts described above, ProPAC is interested in identifying the reasons for the suspected vulnerability of rural hospitals. Analysis will focus on identifying factors contributing to lower costs, characteristics of access, and organizational trends of rural hospitals, with an emphasis on small rural hospitals. This information is necessary in order to determine the extent of problems facing rural hospitals and whether adjustments can be made to PPS, as currently structured, to alleviate these problems.

Disproportionate Share Hospital Adjustment

The Commission has completed analyses supporting its recommendation to develop a definition of hospitals that serve a disproportionate share of low-income patients and implement a payment adjustment for these hospitals. ProPAC will continue to monitor efforts by the Secretary and the Congress to implement such an adjustment.

Capital Payments Under PPS

ProPAC conducted and reviewed a number of analyses to support its recommendations on capital payment under PPS. The Commission also identified several additional areas for analysis of capital payment under PPS. Thus, the Commission intends to include the following topics on its near-term analytic agenda.

Impact of the Capital Payment Proposal.—The Commission will continue to examine the effects of its capital payment proposal on hospitals. Efforts will focus on identifying types of hospitals that may be disproportionately affected by the proposal due to their unique financial positions. ProPAC will examine appropriate provisions for these hospitals in the event that remedies are required.

The Commission will also examine recent hospital capital investment strategies and their effect on capital spending. For example, ProPAC is interested in the extent to which recent capital expenditures are related to expansion of outpatient services. If recent capital purchases are more heavily devoted to outpatient services, estimates of Medicare inpatient capital-related spending may be overstated.

Finally, the Commission intends to study the impact of incentives introduced by the proposed capital payment system. Specifically, by incorporating capital into PPS, hospitals may increase

outpatient services in order to recover more of their capital costs. Furthermore, the Commission is concerned about the impact of implementing a capital payment system that pays hospitals based on volume rather than on costs. The Commission will identify instances where the proposed payment basis might produce undue hardships for some hospitals and beneficiaries.

The Capital Component of the Hospital Market Basket and Capital Trend Factors.—Under an all-inclusive rate, as recommended by ProPAC, the hospital market basket must be revised to reflect the inclusion of capital. The Commission intends to examine proxies for changes in fixed and moveable capital and their appropriateness for inclusion in the hospital market basket. In addition, the Commission will participate in determining the most appropriate indexes for trending base year fixed and moveable capital amounts forward to 1987. Efforts will focus on identifying data to be used for the trending factors and the application of the factors to baseline amounts.

Construction Capital Cost Variations.—Using existing data sources, ProPAC will study the extent to which construction capital costs vary across regions of the country. This study is designed to determine whether capital market areas exist and, if so, how they relate to the labor market areas defined under PPS. Results of this analysis will enable the commissioners to make judgments about the need for payment adjustments for geographic variations in construction capital costs.

Effects of the Addition of Capital on Payment Components.—The Commission recommendation regarding the method of capital payment requires recomputing the components of PPS payments when appropriate data become available. ProPAC will analyze what effect the addition of capital has on the standardized amounts and the proportions for labor and nonlabor components. Analysis will include determination of the impact of capital inclusion on PPS adjustments, such as the indirect teaching and disproportionate share adjustments.

Separation of Fixed and Moveable Capital.—The Commission will examine technical issues concerning identification and separation of costs related to fixed and moveable capital. This will include an examination of the methods used to allocate fixed and moveable capital on the Medicare Cost Report. The Commission will also examine potential effects of the different treatment of these capital components on hospital behavior during the capital transition period.

DRG Capital Intensity Variations.—One of the capital payment evaluation criteria that the Commission regards as most important is that the payment mechanism should reflect capital intensity variations across DRGs. Many believe that existing charge-based weights reflect accurately the relative capital intensity of the DRGs because hospitals' billed charges include operating and capital expenses. The Commission will analyze this issue and recommend appropriate adjustments if needed.

Hospital-Level Effects of PPS

The Commission has developed a microsimulation model of PPS payments, based on HCFA data bases, to study the distributional effects of PPS payment policies on hospitals. This model was used in the Commission's analysis of the transition to national rates. It will also be used to evaluate the effects of future policy changes on hospitals.

In particular, the model will be used to analyze the effects of policy changes on different groups of hospitals or hospital types; that is, by region, bedsize, teaching status, urban/rural status, and disproportionate share status. Furthermore, the model will be expanded to incorporate other data bases, such as the American Hospital Association Annual Survey and the Area Resource File.

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ASSESSING THE EFFECTS OF PPS ON CARE FOR BENEFICIARIES

The Commission strongly believes that implementation of its recommendations will enable hospitals to maintain delivery of high-quality care for beneficiaries. It will, however, devote a significant portion of its resources to studying access and quality. While payment levels are currently adequate for the provision of quality inpatient care, changes in hospital services could diminish access to needed care or affect the quality of that care. Therefore, it is essential to continue to examine the relationship between payment levels and access to quality health care.

Unfortunately, no generally accepted basis for judging the effects of PPS on quality of care exists, and empirical evidence is limited. The Commission is keenly aware that the financial incentives of PPS may lead hospitals to undertake actions that could compromise quality of care. Furthermore, ProPAC is aware that incidents of compromises in quality have been reported and that there are perceptions among some beneficiaries and providers that quality has suffered. Recognizing this, during the past year the Commission has evaluated how it can best contribute to analyzing the effects of PPS on quality of care. This section outlines the Commission's strategy.

Developing ProPAC's Analytic Strategy for Quality of Care

The Commission recognizes that, with limited resources, consideration of quality issues needs to be carefully defined and targeted. The Commission, therefore, allocated staff resources during the past year to the following activities:

- Monitoring studies related to quality of care undertaken by organizations inside and outside of the federal government,
- Consulting with individuals with different perspectives on the quality issue to discuss ProPAC's role in analyzing quality of care,
- Assessing the activities of the PROs in measuring and maintaining quality of care for Medicare beneficiaries, and
- Conducting a study to provide information to support future judgments about the existence of problems and define areas for future studies.

The Commission's study consisted of a systematic review of anecdotal evidence and perceptions related to quality of care. Evidence, in the form of reported incidents and interviews with industry and beneficiary representatives, identified areas most sensitive to changes in quality. The following perceptions were most frequently cited:

- Patients are being discharged "quicker and sicker."
- Appropriate alternative providers are not routinely accessible or available.
- Providers misunderstand how PPS is supposed to work and may risk compromising quality, while beneficiaries are not informed of their rights of appeal within the system.
- PROs have focused on utilization review and do not have sufficient resources to adequately monitor quality of care.

The information obtained from the activities described above enabled the Commission to develop recommendations regarding the PROs, beneficiary and provider information, and beneficiary rights. Furthermore, this information served as the foundation for the Commission's quality of care research strategy.

Analysis of Beneficiary Cost Sharing

The Commission is concerned that changes in health care delivery, including shorter inpatient stays and increased reliance on outpatient surgery, may reduce beneficiary access to medical services. This may occur because beneficiaries have become financially responsible for a larger portion of the cost of their care. If services are not provided during an inpatient stay, beneficiaries pay a larger proportion of Medicare-covered services that are not provided during an inpatient hospital stay. For example, beneficiaries are responsible for 20

percent of the approved charge for outpatient surgery covered under Medicare Part B. Though "Medigap" coverage pays this coinsurance for most beneficiaries, beneficiaries must pay higher premiums for these policies. In addition, Medicare coverage for services received in post-discharge settings is extremely limited. Most Medicare supplemental insurance policies do not cover services excluded from Medicare. ProPAC will continue to examine the increasing proportion of health care costs paid by beneficiaries and the effects of this shift.

The Commission believes that Medicare beneficiaries should share in cost reductions resulting from PPS incentives. It has recommended a change in the method of computing the beneficiary inpatient hospital deductible. The current deductible formula is based on the cost of an average hospital day. As a result, the recent declines in hospital length of stay have accounted for half the increase in the deductible for 1986. The Commission will examine alternative methods for structuring beneficiary cost sharing as the incentives of PPS change hospital practice. For example, the Commission will examine the relationship between outlier cases and Medicare coinsurance.

Analytic Agenda for Quality of Care Research

ProPAC's quality of care analytic agenda focuses on two major research activities. First, the Commission will attempt to detect possible problems related to quality by conducting a series of studies targeted at specific patient groups. Second, the Commission will examine hospital discharge planning practices under PPS to obtain insight into patients' conditions at discharge and their access to post-discharge care. The Commission is also interested in other methods for examining the post-discharge needs of patients, assessing the outcomes of episodes of illness, and disseminating beneficiary information and appeal rights. ProPAC's current direction for quality of care research and its developing analytic agenda are presented below.

Targeted Studies

The Commission's objective in conducting targeted studies is to monitor indirect measures of quality in order to isolate possible problem areas that merit more in-depth review. The studies will focus on changes in specific quality indicators for all beneficiaries and for targeted beneficiary groups believed to be most vulnerable to quality problems.

Quality Indicators.—Using routinely collected data, ProPAC will compare quality indicators during pre- and post-PPS periods. Indicators, or quality proxies, will include length of stay, readmissions, transfers, use of selected ancillary services, complication rates, mortality rates (overall and in-hospital), and emergency visits per discharge. Analysis of quality indicators will use the most current PPS data. In addition, the Commission will monitor the development of improved data bases by HCFA and others for use in its studies. While analysis of quality proxies has limitations, it nonetheless may identify areas for further study or improvement.

Selected Beneficiary Groups.—A major concern related to quality of care is that certain groups of patients with higher-than-average resource needs are more vulnerable to access and quality problems. The Commission will target its analysis of quality indicators on these groups.

One such group, the "frail elderly," is of particular concern to the Commission. This group can be characterized in several ways: the old elderly (e.g., 80 years of age of older), elderly patients having multiple illnesses; or poor elderly beneficiaries. ProPAC's review of anecdotal evidence related to quality indicated several incidents involving the "frail elderly." In addition, industry representatives, beneficiary groups, and health care researchers have expressed concerns for these patients. They fear that the frail elderly are more susceptible to the incentives for hospitals to treat the profitable patients and refer the unprofitable patients elsewhere.

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Study of Discharge Planning Under PPS

The Commission has chosen to examine the discharge arrangements hospitals make for beneficiaries from the many possible subjects for quality of care assessment. It is concerned about perceptions that hospitals are prematurely discharging patients and that appropriate post-discharge care is not consistently accessible or available.

To examine this aspect of health care quality, ProPAC will examine hospital discharge planning —an activity intended to connect inpatient hospital care with needed post-discharge care. Discharge planning activity is one measure that can be used to judge the availability of appropriate post-discharge care for beneficiaries. Results of this study may provide guidance for developing quality of care studies that focus on the complete episode of illness.

In its study, the Commission expects to learn how well local health care services are matched with Medicare patients who need post-discharge services. Initially, the Commission will look at the methods, resources, and criteria that hospitals use to discharge patients. The study will evaluate how discharge planning is organized within the hospital, including staffing patterns. It will also examine how available post-discharge services are identified. Finally, the Commission will explore how patients are channelled to appropriate post-discharge services, particularly for patients in areas with limited local supply of post-discharge services.

ProPAC's future research on access and quality will build on findings from this study.

Additional Efforts To Monitor Quality of Care

The dramatic decline in length of stay since the introduction of PPS requires careful monitoring. While this trend was emerging before the introduction of the system, PPS offers extraordinary incentives for hospitals to discharge patients earlier. The Commission is interested in the relationship between shortened hospital stays, the use of medical services at alternative sites of care, and health care outcomes.

Using information derived from the studies described above, ProPAC will develop post-discharge analyses that look more closely at this issue. Specifically, the Commission is interested in observed changes in patient case mix, disposition, health status, functional status, and satisfaction as well as sources and adequacy of care.

In the long-term, the Commission will focus on patients episode of illness. This type of analysis includes assessing all care provided to the beneficiary—preadmission services, acute care, acute after-care, long-term care, home health care, and ambulatory services. Conducting this type of analysis requires combining data that reflect all care the patient receives. ProPAC believes that the primary measure of quality care is the outcome of the episode of illness. The Commission recognizes, however, that development of appropriate data bases will require extensive resources and time. Nevertheless, the Commission will monitor activities in this area and contribute to this effort where appropriate.

ProPAC's review of beneficiaries' perceptions of hospitalization under PPS, as well as information obtained from other sources, clearly indicate a misunderstanding of the basic mechanics of PPS among hospitals, physicians, and beneficiaries. The Commission has made specific recommendations to address this problem. ProPAC will continue to monitor the dissemination of clear, accurate, and helpful information about PPS.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[BERC-357-FN]

Medicare Program; Changes to the DRG Classification System

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final notice.

SUMMARY: In the final rule published September 3, 1985 on the prospective payment system for inpatient hospital services (50 FR 35646), we stated that we would publish a later notice addressing issues related to the Diagnosis-Related Group (DRG) classification system. On March 13, 1986 we published that notice in the **Federal Register** (51 FR 8762). In that proposed notice, we responded to comments received on the DRG classification system, discussed Medicare coverage changes affecting the DRG system, listed procedures for which new identifying codes (in the coding system of the International Classification of Diseases—9th Edition—Clinical Modification (ICD–9–CM) on which DRG assignments are based) have been proposed, and proposed certain changes in the DRG classification system to resolve some of the problems identified by comments and our analysis up to that time.

This final notice responds to comments received on the March 13 proposed notice and makes final the proposals contained in that notice.

FOR FURTHER INFORMATION, CONTACT: Linda Magno, (301) 594–9343.

EFFECTIVE DATE: These classification and coding changes are effective for discharges occurring on or after October 1, 1986.

SUPPLEMENTARY INFORMATION:

I. Background

A. Prospective Payment System—General

Under section 1886(d) of the Social Security Act (the Act), enacted by the Social Security Amendments of 1983 (Pub. L. 98–21) on April 20, 1983, a prospective payment system (PPS) for Medicare payment for inpatient hospital services was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment is made at a predetermined, specific rate for each discharge; that payment varies by the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The list of DRGs currently contains 471 specific categories. All but 3 DRGs are categorized into 23 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body. A few, such as MDC 14 (Pregnancy, Childbirth and the Puerperium) and MDC 22 (Burns), are not, because they involve multiple organ systems.

The formula used to calculate payment for a specific case takes a hospital's payment rate per case and multiplies it by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the national average resources consumed per case by the average hospital. Thus, cases in a DRG with a weight of 2.0 would, on average, require twice as many resources as the average case for the average hospital.

B. Basic DRG Classification System

The method of classifying cases into DRGs for payment under the prospective payment system involves a number of steps. First, the physician enters into a patient's medical record the principal diagnosis, any additional diagnoses, and any procedures performed during the stay. This information is expressed by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9–CM). The principal diagnosis, as many as four additional diagnoses, the principal procedure, and as many as two additional procedures are reported, along with a patient's age, sex, and discharge status, to the hospital's fiscal intermediary on the hospital request for payment.

The intermediary then enters the information into its claims system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

After screening through the MCE and any further development of the claims cases are classified by the GROUPER software program into the appropriate DRG. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). It is used to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights, and to classify current cases for purposes of determining payment.

Principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. Medical DRGs are differentiated on the basis of diagnosis, age, and presence or absence of complications or comorbidities only. Generally, GROUPER does not look at other procedures; that is, those not surgical or those minor surgical procedures generally not done in an operating room and therefore not recognized as surgical by GROUPER.

C. Changes to the DRG Classifications and Weighting Factors

1. General

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. In addition, Congress provided the Secretary with authority to reclassify diagnoses and procedures within the DRG system to take into account changes in medical technology and treatment patterns. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and weighting factors effective for discharges occurring in FY 1986 and at least every four fiscal years thereafter. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The intention of Congress was that we would make changes as often as needed to achieve the objectives of the prospective payment system, including the need to keep current with developments in the areas of coverage and medical technology.

2. Publication of Proposed and Final Rules—1985

On June 10, 1985, we published a notice of proposed rulemaking (NPRM or proposed rule) in the **Federal Register** (50 FR 24366) to update the prospective payment system in general. As part of that NPRM, and as required by section 1886(d)(4)(C) of the Act, we proposed to adjust the DRG classifications and weighting factors for discharges beginning with Federal fiscal year (FY) 1986.

On September 3, 1985, we published a final rule in the **Federal Register** (50 FR 35646) concerning the prospective payment system. We included in that rule the classification changes proposed in the June 10 proposed rule as we had modified them in response to coments and suggestions we received on the NPRM. We also included some

additional changes that followed the principles discussed in the proposed rule or that were similar to them. (As a result of the Emergency Extension Act of 1985 (Pub. L. 99-107) and subsequent extensions of that Act (Pub. Laws 99-181, 99-189, 99-201, and 99-272), the classifications and weights established by the September 3, 1985 final rule did not go into effect until May 1, 1986.)

We indicated in the final rule that we could not address certain classification issues that were raised in the NPRM comment period for various reasons; we also noted that those comments would be analyzed and reviewed during the several months after publication of the September 3 final rule and that actions on them would be published in a notice early in 1986. Also, we solicited comments on any other proposed classification changes, and provided an address for such comments.

II. Provisions of the Proposed Notice

In keeping with our commitment just discussed, we published a proposed notice in the **Federal Register** on March 13, 1986 (51 FR 8762). In that proposed notice we responded to comments received on the DRG classification system, discussed Medicare coverage changes affecting the DRG system, listed procedures for which new ICD-9-CM codes had been proposed, and proposed certain changes in the DRG classification system to resolve some of the problems identified by comments and our analysis up to that time. The provisions of the proposed notice follow.

A. Proposed Changes Resulting from Comment Process

1. *MDC 4: Diseases and Disorders of the Respiratory System.* We proposed to remove diagnosis code 4828 (Bacterial pneumonia not elsewhere classified) from DRGs 89, 90, and 91 (Simple Pneumonia and Pleurisy: Age over 69 and/or complications or comorbidities[1], Age 18-69 without C.C., and Age 0-17, respectively). We would place this code into DRGs 79, 80, and 81 (Respiratory Infections and Inflammations; Age over 69 and/or C.C., Age 18-69 without C.C., Age 0-17 with C.C., respectively.

2. *MDC 13: Diseases and Disorders of the Female Reproductive System.* We proposed to reconfigure DRGs 353, 354, 355, 357, 358, 359, 360, 361, and 362 to increase homogeneity and thus more accurately reflect resource intensity of cases assigned to these DRGs.

3. *MDC 20: Substance Use and Substance Induced Organic Mental Disorders.* We proposed to change the titles of DRGs 433 through 437 in MDC 20. Wherever the term "substance" appears in those DRGs we would substitute the term "alcohol/drug".

B. New Coverage Decisions

1. *Background.* Under § 412.10(c) of the regulations, we may make interim changes in the DRG classifications to reflect new additions to coverage made by the Medicare program. Such classification changes are to be included in the next annual notice of DRG classification changes and be subject to public comment.

Effective for procedures performed on or after January 24, 1986, Medicare coverage was extended to implantation of cardiac defibrillators under certain circumstances.

2. *Proposals.* We stated in our proposed notice that on an interim basis we will pay for this procedure using the weight for DRG 104 (Cardiac Valve Procedure with Pump and with Cardiac Catheter) for the time being and we solicited comments as to whether it may be more appropriate to use another DRG, such as DRG 109 (Cardiothoracic Procedures without Pump) or DRGs 115 and 116 (Permanent Cardiac Pacemaker Implant; with AMI, Heart Failure or Shock, and without AMI, Heart Failure or Shock, respectively).

Discrete ICD-9-CM procedure codes for this new technology had not yet been adopted. Consequently, for the present, we stated that payment will be made for such claims only on a manual basis when accompanied by appropriate documentation. We indicated that the ICD-9-CM Coordination and Maintenance Committee (a description of this committee is contained in section C, following) was considering new ICD-9-CM procedure codes for the implantation of cardiac defibrillators and that if these proposed new codes were adopted, we proposed to add the new procedure codes to the appropriate DRG.

C. New Coding Changes

1. *Background.* A Federal inter-agency committee, the ICD-9-CM Coordination and Maintenance Committee, has been formed to evaluate the International Classification of Diseases—9th Edition—Clinical Modification, (ICD-9-CM) updating and use for Federal programs. This committee holds public meetings quarterly for discussion on educational issues and proposed coding changes. Many of the proposed coding changes will result in one or more specific codes to identify discretely those diagnoses or procedures that are currently being coded under a more general diagnosis or procedure.

We noted in the proposed notice that new ICD-9-CM codes had been proposed to identify the following:

A. *Cochlear Prosthetic Device Implant.*

B. *Percutaneous Transluminal Coronary Angioplasty.*

C. *Cardioverter/Defibrillator.*

D. *Thoracoabdominal Aortic Aneurysm Repair.*

E. *Lithotripsy.*

F. *Artificial Urinary Sphincter Implant (AUS).*

G. *Penile Prosthesis—Inflatable and Non-Inflatable.*

H. *Chemonucleolysis.*

I. *Magnetic Resonance Imaging (MRI) and Intraoperative Ventricular Mapping.*

2. *Proposals.* In order to prevent the unwarranted delay of recognition of new codes by the Medicare program, we proposed to modify the GROUPER program, to the extent feasible, to recognize any new ICD-9-CM codes adopted in the future by the ICD-9-CM Coordination and Maintenance Committee and, in most cases, to classify discharges with such codes initially in the same DRG as the previous coding assignment. That is, any coding changes adopted by the committee prior to July 1, 1986 would be included in the Medicare GROUPER program for Federal fiscal year 1987 (October 1986 through September 1987), but would not necessarily result in changes to the classification of cases using these new codes. In addition, we indicated that we would consider interim revisions of the GROUPER to recognize new ICD-9-CM codes, should the volume of cases indicate it is appropriate. Because the use of most new ICD-9-CM codes would not result in DRG classification changes initially, the new codes would not be published for public comment. Of course, should reclassification become necessary, we stated we would follow the procedures set forth at § 412.10 of the regulations.

D. Effective Dates

We proposed that the changes in DRG classification and adoption of new ICD-9-CM codes set forth in the proposed notice would become effective for discharges occurring on or after October 1, 1986.

III. Summary of Comments on Proposed Notice

We received 19 public comments concerning changes to the DRG classification system. These comments were from health care associations, hospitals, The Prospective Payment Assessment Commission (ProPAC),

[1] Complications or comorbidities is henceforth abbreviated C.C.

physicians and physician associations, businesses, researchers, and medical record administrators. ProPAC incorporated by reference its recommendations on DRG classifications included in its April 1, 1986 report to the Secretary. These recommendations are discussed in detail in the proposed rule setting forth PPS rate and changes for fiscal year 1987.

In addition to the specific comments discussed in sections IV through VII, below, we received some comments of a general nature.

Comment: One commenter expressed concern with our failure to provide what he believes to be sufficient information on changes affecting the Medicare program and the inadequate time period given to the industry to respond. The commenter recommended that full disclosure be made of the methodologies, criteria, calculations, supporting documentation and underlying assumptions used to reach conclusions. He stressed the need for independent evaluation of proposed changes using non-billing abstract data such as that maintained by CPHA. Finally, he requested that revised software and associated documentation be made available to the industry prior to the publication of final changes.

Response: We responded to a similar concern regarding availability of data in the September 3, 1985 final rule on the prospective payment system (50 FR 35657). As we pointed out in that publication, we have not provided the level of detail requested by the commenter due to the fact that such data is quite voluminous and would be of limited interest to the majority of readers. We believe we provided information in sufficient detail to allow for informed public comment. In this regard, we believe we have complied with the Administrative Procedure Act (5 U.S.C. 553). Moreover, more detailed information is available, to the extent it is disclosable under the Freedom of Information Act, to interested parties upon request.

We do not believe it is necessary or appropriate to revise GROUPER software prior to the publication of final changes based on proposed changes. This process could involve substantial costs in modifying and testing software for proposed changes that may never occur. Further, were we to develop the software changes at the time of a proposed notice, making classification changes beyond those originally proposed as a result of public comments or ProPAC's recommendations would further increase the number of software modifications necessary. Duplicating software modification costs by preparing one revision of GROUPER for proposed changes and a final revision to GROUPER once the final rule is prepared clearly is not cost effective.

Based on the specificity contained in the proposed notice, interested parties can identify cases that would be moved and assess how they would be affected. We believe this is sufficient to allow the industry to evaluate proposed changes.

Further, we do not agree that independent evaluation of the Medicare DRG classification system using non-Medicare claims data is necessary or advisable. As we pointed out in the June 10, 1985 **Federal Register** (50 FR 24373), "other payors of health care services that may be interested in using a hospital prospective payment system should recognize that DRG classifications and weights developed from Medicare discharges may not be appropriate for use in the payment of non-Medicare cases." We continue to believe it is inappropriate to revise the Medicare DRGs based on analysis of their effect on non-Medicare patient populations.

Finally, with regard to the length of the comment period, we emphasize that we recognize the importance of affording the public the opportunity to analyze the many issues raised in the document and to express their views. However, givens our commitment to publish a final DRG reclassification notice prior to or simultaneous with the proposed rule setting forth prospective payment system rates and changes for FY 1987, we had little alternative to limiting the comment period to 30 days. In order to analyze as many issues as possible and provide as complete a document as possible, extensive lead time is necessary. If we published the proposed notice earlier so as to provide for a longer comment period, it is likely that fewer classification changes would be considered because the time available to perform necessary analysis would be reduced. Finally, we note that the March 13, 1986 notice proposed only a small number of changes. We believe 30 days should be sufficient time to review and comment upon these few issues. We should point out, however, that comments are accepted and considered at any time, not just during the formal public comment period. Any proposed DRG classification changes should be made in writing. They should state succinctly the issue of concern. Any rationale for the change or supporting documentation should be included in the proposal and sent to the following address: The Health Care Financing Administration, Department of Health and Human Services, Grouper Changes, P.O. Box 26681, Baltimore, Maryland 21207.

IV. Comments and Responses on Proposed DRG Classification Changes

A. MDC 2: Diseases and Disorders of the Eye

Comment: One commenter disagreed with our position regarding classification of lens extractions involving anterior chamber injections to DRG 39 (Lens Procedures). The commenter believes that since DRG 42 procedures (Intraocular Procedures Except Retina, Iris and Lens) are ordered above lens procedures in the surgical hierarchy, lens procedures involving anterior chamber injections should be classified based on the higher weighted procedure. The commenter believes the current classification penalizes hospitals for clinical problems of their patients over which they have no control.

Response: We continue to believe, based on our analysis of the data, that anterior chamber injections in lens extractions cases are incidental procedures. As such, they should not drive the DRG classification of the cases. Moreover, we believe that it is clinically inconsistent to classify lens extraction cases to a DRG which specifically excludes lens procedures.

In addition, were we to classify lens extraction cases involving anterior chamber injection to DRG 42, they would represent approximately 15 percent of the total volume of cases in this DRG. To the extent that the average charge for such cases is lower than the average charge for intraocular procedures currently assigned to DRG 42, such a process would inappropriately reduce the weighting factor for this DRG.

B. MDC 5: Diseases and Disorders of the Circulatory System

Comment: One commenter objected to our decision (set forth in the September 3, 1985 final rule) to reclassify all procedures coded 360 (removal of coronary artery obstruction) that do not require a heart pump to DRG 112 (Vascular Procedures Except Major Reconstruction, Without Pump). He recommended instead that an edit be performed on all procedures coded 360. Only those cases involving percutaneous transluminal coronary angioplasty (PTCA) should be classified to DRG 112.

Response: The ICD–9–CM Coordination and Maintenance Committee has approved a unique code for PTCA. GROUPER will recognize and

assign such cases to DRG 112 effective for discharges on or after October 1, 1986. The new procedure code for open chest coronary angioplasty will be reassigned to DRG 109 as it was before the FY 86 change. Thus, cases involving open chest coronary angioplasty, such as endarterectomy, will be assigned to DRGs 108 (Other Cardiovascular or Thoracic Procedures, With Pump) or 109 (Cardio Thoracic Procedures Without Pump) depending upon the use of extracorporeal circulation. Since this issue will be remedied within a few months, we do not believe it is necessary to develop the edit procedure suggested.

Comment: One commenter suggested that the problem with the pacemaker DRGs 115, 116, 117, and 118) may be related to ICD–9–CM limitations rather than with proper application of existing codes.

Response: We agree that the ICD–9–CM procedure codes for pacemaker implantation and revision need review and may need modification. The ICD–9–CM Coordination and Maintenance Committee is evaluating this issue in conjunction with the recommendation presented by ProPAC.

If revised codes are adopted prior to July 1, 1986, they will be recognized by the GROUPER program for discharges on or after October 1, 1986.

Comment: One commenter expresed concern that the difficulty with the weight for several of the DRGs in MDC 5 was related to both a misunderstanding of coding guidelines and the quality of PRO review when applying the guidelines. He specifically cited the increase in the number of cases assigned to DRG 140 (Angina Pectoris) as evidence of this problem. However, no specific information was provided as to which coding guidelines were being misapplied.

Response: We share the commenter's concern that appropriate coding guidelines be consistently applied in reporting diagnoses and procedures on Medicare claims. As the commenter points out, inappropriate coding of cases can adversely affect the homogeneity of the DRGs and produce inappropriate weighting factors at recalibration.

This is largely an educational problem that requires the cooperation of the industry as well as the government to correct. We have been working with the American Hospital Association's editorial advisory board for the *Coding Clinic for ICD–9–CM* in reviewing and reemphasizing appropriate coding guidelines. We also participate on the ICD–9–CM Coordination and Maintenance Committee, which has as one of its missions educational activities related to appropriate use of ICD–9–CM codes. In addition, each PRO is being required to include a registered record administrator (RRA), or accredited record technician (ART) as the individual responsible for the overall DRG evaluation process and will utilize individuals trained and experienced in ICD–9–CM coding to perform the DRG validation process. Finally, we have established an internal coding workgroup to review coding issues. Through all these avenues, we are striving to improve the quality of data available for analysis or classification issues and recalibration of the DRGs. However, without specific information on which coding guidelines are being misapplied in these cases, we are not able to assist in correction of the alleged problem.

Comment: One commenter noted that in his review of hospital records, he found that physicians were recording thrombophlebitis when the medical record documentation indicated thrombosis was present. He believes that lack of specificity on the part of the attending physician is largely responsible for the disparity in the weighting factors for DRGs 128 (Deep Vein Thrombophlebitis) and 130 (Peripheral Vascular Disorders; Age Over 69 and/or C.C.) which are .8456 and .8254, respectively. He recommended further study in this area.

Response: We support the commenter's concern that physicians be attuned to accuracy and specificity in description of a patient's diagnosis. This is an educational problem that cannot be addressed by HCFA alone. Rather, improvement in this area requires the support of the entire medical community. Educational activities conducted by hospitals and reports in medical journals are likely to be more successful in this regard than any action on the part of the government. However, the Utilization and Quality Control Peer Review Organizations (PROs) do correct claims data and make educational contacts with physicians and hospital staff when they discover errors or lack of specificity in recording diagnosis and procedures.

However, we should note that certain types of both thrombosis and thrombophlebitis are included in both DRGs 128, 130, and 131. For example, both vena cava thrombosis (diagnosis code 4532) and thrombophlebitis leg, not otherwise specified (diagnosis code 4512) are included in DRG 128, while both venous thrombosis, not otherwise specified (code 4539) and thrombophlebitis, not otherwise specified (code 4519) are classified into one of the DRG pair 130–131 (Peripheral Vascular Disorders). Thus, it is not clear that the coding problem cited by the commenter is responsible for the minimal difference in the weighting factors for these DRGs.

Comment: One commenter objected to the length of stay data for infective endocarditis and osteomyelitis. The commenter stated that texts recommend a minimum interval of therapy for osteomyelitis of 28 days and for infective endocarditis of 28 to 42 days. He believes that the weighting factors are based on 12 and 18 days of care respectively, and therefore encourage premature discharge of a patient or force hospitals to incur substantial losses.

Response: The crux of this commenter's concern centers on the recurring issue of inappropriate reference to the length of stay data. The DRG classification system has established separate DRGs for acute and subacute endocarditis (DRG 126) and osteomyelitis (DRG 238). The weighting factors for these DRGs are based on average standardized hospital charges for all Medicare cases with these diagnoses. Consequently, payment levels reflect resources used in the actual average treatment patterns for such cases.

While it is true that the geometric mean length of stay, which is used only for purposes of calculating outlier or transfer payments, shows mean lengths of stay for endocarditis and osteomyelitis of 18.1 and 11.1 days, respectively, the arithmetic mean length of stay for each of these DRGs is considerably higher (23.8 and 15.8, respectively), indicating that there are some very long stays in these DRGs. As we have stated many times, the mean length of stay data for any DRG are not intended to reflect treatment protocols. Rather, each patient should be treated based on his or her medical needs.

We also wish to point out that during 1985 ProPAC investigated a similar allegation concerning treatment of infective endocarditis. They discovered, "It appears that the arithmetic mean length of stay for patients being treated for infective endocarditis was appropriate." (Technical Appendixes to the Report and Recommendations to the Secretary, U.S. Department of Health and Human Services April 1, 1986, page 80, topic number 17–85.)

C. MDC 6: Diseases and Disorders of the Digestive System

Comment: One commenter objected to our analysis concerning our decision not to include procedure code 5499 (abdominal region operation, not elsewhere classified) as an operating

room procedure. The commenter acknowledged that the code is broad in scope and covers a number of procedures, some of which do not require use of an operating room. However, he believes this should not be used to penalize hospitals. He also recommended that percutaneous extraction of common duct stones (procedure code 5196) be added to the list of operating room procedures.

Response: The problem of broad procedure codes that are used to identify numerous kinds of procedures, only some of which require an operating room, affects numerous DRGs. We are studying this issue generically, rather than on a DRG-specific level. We are working to develop an administrative mechanism whereby we can identify procedures that involve the use of an operating room, percutaneous approaches, endoscopic methods, etc. If such a mechanism is adopted, the DRGs may be revised accordingly once data are available.

D. MCD 8: Diseases and Disorders of the Musculoskeletal System and Connective Tissue

Comment: One commenter reemphasized the need for separate DRGs involving multiple procedures. He specifically recommended that multiple limb reattachments be classified into DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremities).

Response: We believe the creation of separate DRGs for multiple procedures is best addressed on an individual basis, although we would note that the general issue of additional resources associated with multiple procedures is being considered in our research on severity of illness. With regard to the specific need to include multiple limb reattachments into DRG 471, we will investigate this matter using more recent Medicare data and report our findings in the future.

Comment: One commenter continues to believe that replacing or repairing a major joint prosthesis should be assigned to DRG 209 (Major Joint and Limb Reattachment Procedures), rather than to one of the DRG pair 442–443 (Other O.R. Procedures for Injuries), in MDC 21. He argues that the procedures are equivalent from a resource perspective and that the differences are merely semantic.

Response: We must emphasize that the DRG classification system is a *diagnosis* based system, not a procedure based classification system. As we have pointed out previously, we can consider reclassification actions only to the extent that they comport with the basic framework of the classification system. Given the way the ICD–9–CM classification system is structured, numerous procedure and diagnosis codes may affect multiple organ systems. For example, infections, poisoning, toxic effects of drugs, burns, shock, and complications all may affect multiple organ systems. The DRG system responds to these multiple system diagnosis codes through the creation of several MDCs that are not organ-system specific, such as MDC 21 (Injury, Poisoning and Toxic Effects of Drugs), MDC 22 (Burns), MDC 23 (Factors Influencing Health Status), etc.

Moreover, the DRG system is structured so that each diagnosis code occurs in only one MDC. Thus, were we to reassign the nonspecific complication codes to MDC 8, all complications would be assigned to the musculoskeletal system, regardless of what organ was affected. Such an occurrence would seriously disrupt the clinical coherence of the DRGs as well as the homogeneity of resources associated with the DRGs. However, if future revision of the coding system should permit more precise identification of the organ system involved in infection and complication diagnoses, we will consider classification changes at that time.

Comment: One commenter noted ProPAC's recommendation (Recommendation 32: Upper Extremity Procedures on page 55 of ProPAC's April 1, 1986 Report) concerning reclassification of hand procedures. The commenter urges HCFA to adopt ProPAC's suggested classification.

Response: We believe the ProPAC recommendation has merit and are proposing to adopt reclassification of DRGs 223–224 (Upper Extremity Procedures Except Humerus and Hand) 228 (Ganglion (Hand) Procedures), and 229 (Hand Procedures Except Ganglion). For further details on this issue see the proposed rule on PPS changes for FY 1987.

E. MDC 9: Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast

Comment: One commenter continues to object to the addition of procedure codes 0722 (unilateral adrenalectomy), 073 (bilateral adrenalectomy), 0763 (partial excision of pituitary gland), 0769 (total excision of pituitary gland), and 6561 (removal of both ovaries and tubes at same operative episode) to the DRG pair 269–270 (Other Skin, Subcutaneous Tissue, and Breast O.R. Procedures), contending that they change the clinical homogeneity of the DRGs.

Response: We have responded to this comment in both the September 3, 1985 and March 13, 1986 **Federal Registers.** We continue to believe this change is appropriate. Unless presented with specific evidence, as opposed to a mere allegation, that homogeneity is altered, we do not have a basis to study this issue further. We should point out that when we compared the effect of this change to retaining the FY 1985 classification structure, we found that the addition of all 10 procedures to DRG 269 resulted in 866 cases being assigned to this DRG, in addition to the 19,553 cases that would have been assigned absent these changes. The average standardized charge of DRG 269 was altered by less than 3 percent as a result. The change impacted DRG 270 by adding 431 cases, with only a one-percent resulting change in the average standardized charge. We believe the minimal effect of these changes supports our conclusion that addition of these procedures is appropriate.

F. MDC 10: Endocrine, Nutritional and Metabolic Diseases and Disorders

Comment: One commenter objected to a change in GROUPER logic that was included in the September 3, 1985 final rule pertaining to classification of diabetes mellitus. Basically, GROUPER now classifies diabetic cases with a manifestation of a disease process, which is coded using one of the combination codes in the 250 series, into the organ system in which the disease manifestations occur. The commenter objected to this change with regard to reclassification of cases out of DRG 285 (Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders). She believed amputations for diabetic patients should be classified to DRG 285 as they were previously.

Response: We can appreciate the commenter's desire that amputations on diabetic patients be classified into the highest weighted DRG. However, we do not believe it is appropriate to establish different GROUPER logic for manifestations of different disease in diabetic patients. That is, we do not believe it is appropriate to classify diabetic patients with renal manifestations into the kidney and urinary tract MDC, based on the renal manifestation, and diabetic patients with circulatory manifestations into the endocrine, nutritional and metabolic MDC, instead of the circulatory MDC. In order for a classification to be successful, it must be consistent in its basic underlying logic.

Although this logic change has resulted in classification to a lower weighted DRG in amputation cases, we should point out that in other cases the

change resulted in classification to higher weighted DRGs. For example, this change resulted in reassignment of Kidney transplants on diabetic patients from DRG 468 (weight of 2.4542) to DRG 302 (weight of 4.6273). In addition, we should point out that the reclassification of cases took place before the weights for the DRGs were recalibrated. In this regard, we note that the reclassification of diabetic patients with circulatory manifestation is largely responsible for the significant differences in the weighting factors for DRGs 113 (Amputation for Circulatory System Disorders Except Upper Limbs and Toe) and 285. The FY 1985 weighting factors for DRG 113 (2.6522) and DRG 285 (2.860) were much more closely aligned when diabetic patients with circulatory manifestations were included in DRG 285, than they were in FY 1986 when such patients were classified based on the manifestation (2.5406 for DRG 113 and 3.2724 for DRG 285.) Had diabetic patients with circulatory manifestations not been removed from DRG 285, the FY 1986 weight for this DRG would have been 2.7374.

G. MDC 11: Diseases and Disorders of the Kidney and Urinary Tract

Comment: One commenter complained about GROUPER logic. She noted that a patient admitted for a urinary tract infection could be classified into DRGs 320 (Kidney and Urinary Tract Infections; Age over 69 and/or C.C.). However, if this same patient also received a transurethral bladder biopsy, the case was classified into DRG 310 (Transurethel Procedures; Age over 69 and/or C.C.), which carries a lower weighting factor.

Response: We have receved similar correspondence recently from other sources nothing what they consider to be an anomolous situation of surgical procedures driving classification of a case into a lower weighted. DRG than a medical DRG. We can appreciate the concern about this logic in those cases. However, given the construction of the DRG classification system, it is the presence or absence of surgical procedures, and not the level of weighting factors, that determines whether a case is clasified into a surgical or a medical DRG. Once cases are thus classified, it is the actual average resource intensity of cases in each DRG, relative to the average case in the average hospital, that determines the weighting factors. Revision of the basic GROUPER logic to ensure assignment of a surgical case to a medical DRG only when the medical DRG has a higher weighting factor would radically modify the entire classification structure and may create significant problems in other DRGs. Nonetheless, we will be investigating this issue further throughout the upcoming year.

Comment: One commenter submitted a detailed study of the cost of extracorporeal shock wave lithotripsy (ESWL). In the cases studied, Medicare payment at both DRGs 323 and 324 significantly understated the cost of ESWL. He recommended a separate DRG be established for ESWL cases.

Response: As we noted in the September 3, 1985 final rule, ESWL cases were classified into these DRGs on the basis of both clinical and resource-utilization considerations. That is, the procedure is noninvasive and, as such, belongs in a medical DRG. Moreover, the clinical course of patients treated with lithotripsy, particularly length of stay, more closely resembles that of nonsurgical rather than surgical patients in the renal MDC.

While the study presented interesting findings, the study's conclusions were based on data gathered from fifteen unidentified major medical centers. (There are over 50 hospitals currently providing ESWL.) We are not able to assure that such sampling is statistically valid, or that the study's results represent typical Medicare costs per case. Furthermore, the study's findings regarding the cost per case differed considerably from that of the ProPAC. We have decided, for the interim, to accept ProPAC's recommendation. (See full discussions in the proposed rule on PPS changes for FY 1987.)

H. MDC 12: Diseases and Disorders of the Male Reproductive System

Comment: One commenter noted ProPAC's recommendation concerning implantation of penile prostheses (Recommendation 28: Penile Protheses: page 53 of the April 1, 1986 report). The comment urged us to accept ProPAC's suggestion and establish a separate DRG for penile prosthesis implants.

Response: We do not believe it is appropriate to establish a separate DRG for implant of a penile prosthesis. Readers should see our response to this ProPAC recommendation in the proposed rule on PPS changes for FY 1987.

Comment: One commenter stated that clinical review of patients classified into DRGs 336 (Transurethral Prostatectomy) and 341 (Penis Procedures) support the greater resource intensity of the transurethral prostatectomy cases, given the intensity of ongoing therapy required by these patients. He continues to believe that patients undergoing both an internal urethrotomy and a transurethral prostatectomy should be assigned to DRG 336.

Response: FY 1984 data on Medicare beneficiaries indicate that penis procedures as currently grouped are slightly more intensive than transurethral prostatectomy cases. Should this relationship change, that is, should prostatectomies prove to be more resource-intensive than penis procedures at some time in the future, we would consider modifying the surgical hierarchy to reflect such change. At the present time, however, we do not believe it is appropriate to revise the classification system to provide less payment for cases involving both procedures than would have been available had the patient undergone the internal urethrotomy alone based on the clinical review of unspecified cases by a commenter. Consequently, we have not modified the DRG classifications based on this comment. Moreover, should this comment be arising out of concern that the geometric mean length of stay is lower for DRG 341 than for DRGs 336, we note that Medicare payment is not based on the actual length of stay unless the case meets the outlier threshold. In that regard, we note that the 16-day outlier threshold for DRG 341 is lower than the 18-day threshold for DRG 336. Consequently, outlier payments would be higher for DRG 341 than for 336, because cases would qualify earlier and the payment per day would be higher.

I. MDC 13: Diseases and Disorders of the Female Reproductive System

Comment: One commenter stated that she had modeled the classification changes for MDC 13. She noted that 59 percent of the cases studied that currently are assigned to one of DRGs 354 and 355 (Non Radical Hysterectomy; Age over 60 and/or C.C., and Age under 70 without C.C., respectively) were regrouped to DRG 356 (Female Reproductive System Reconstructive Procedure), which did not make sense clinically. She also noted that 25 percent of the patients who were regrouped into the new DRG 354 fell into this group because they had an incision of the uterus for the purpose of radium implantation, without further comment as to the impact of this observation.

Response: We are not aware of the exact methodology the commenter used in regrouping cases for purposes of her analysis. However, it appears that the methodology may be flawed. All patients currently grouped to DRGs 354 and 355 have undergone a hysterectomy, which is ordered above reconstructive procedures in both the current and proposed DRG surgical hierarchy.

Therefore, all of the hysterectomy cases would be searched out and assigned to DRGs 354, 355, 357, 358 or 359 before GROUPER would consider any reconstructive procedure that may also have occurred. In addition, since we suspect the methodology for analysis of this proposed change was flawed and since no conclusion was drawn from the comment concerning radium implantation, we are not able to respond to this portion of the comment.

J. MDC 14: Pregnancy, Childbirth, and the Puerperium

Comment: One commenter continues to object to the classification of any operating room procedure to MDC 14 (DRGs 378–384) and MDC 17 (DRGs 401, 402 and 408). The commenter believes that the logic that precludes classification to DRG 468 (Unrelated O.R. Procedure) in such cases violates the basic premise of the DRG system.

Response: There is little that we can add to our past responses on these issues. Our medical consultants have advised us that the nature of lymphoma is such that almost any surgical procedure can be performed in relation to the principal diagnosis. However, we are proposing other changes to these DRGs in response to ProPAC's recommendation. (See publication of proposed notice of PPS changes for FY 87).

With regard to MDC 14, it is so rare, especially among the Medicare population, to experience a case where none of the operating room procedures are related to the pregnancy principal diagnosis in appropriately coded claims that it was determined the classification to DRG 468 is unnecessary. We recognize that, despite the attendant risks, surgery is sometime unavoidable during pregnancy, particularly for medical emergencies. However, in most of those cases, the medical condition necessitating the surgery-and *not* the pregnancy-would be the principal diagnosis. We should point out that we are not aware of a single Medicare case for which assignment to DRG 468 would have occurred but for the GROUPER logic as it applies to surgical procedures.

We do not believe this logic violates the basic concept of the classification system. Rather, we believe this logic supports the concept of the establishment of DRG 468 as a unique classification category where none of the surgical procedures are related to the principal diagnosis.

K. MDC 15: Newborns and Other Neonates With Conditions Originating in the Perinatal Period

Comment: One commenter disagreed with our decision to remove diagnosis code 7746 (fetal/neonatal; jaundice, not otherwise specified) from the list of complications and comorbid conditions. He believes newborns afflicted with this condition consume substantially more resources.

Response: Due to the paucity of Medicare data on newborns, our decision in this regard was based primarily on the advice of our medical consultants. While it may be true that some newborns with severe fetal/neonatal jaundice require substantially more resources than other normal newborns, generally this is a transient physiologic condition with minimal resource impact. In addition, since this condition as a principal diagnosis, or as the only secondary diagnosis occurring with a principal diagnosis classified to DRG 391, is considered a normal newborn, it seems logical that this same diagnosis would not be viewed as a significant complication or comorbid condition.

Finally, when considered as part of the entire classification structure of MDC 15, it is very unlikely that the removal of diagnosis code 7746 from the list of complications and comorbidities alters the classification of any cases. Unlike most MDCs, which are partitioned based on the presence or absence of any C.C., MDC 15 is organized by type of C.C. Since fetal/neonatal jaundice, NOS (7746) has never been included in any of the complicated newborn and neonatal DRGs, its presence on the list of C.C.s would affect only cases assigned to other MDCs. In summary, we view the removal of diagnosis code 7746 from the list of C.C.s as a "housekeeping" change, in that its effect upon classification of cases should be negligible.

L. MDC 17: Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms

(See the Comment under MDC 14, which also refers to this MDC.)

Comment: One commenter continues to dispute our conclusion regarding DRG 410 (Chemotherapy). The commenter believes admissions for chemotherapy have historically been coded by the cancer diagnosis, not the chemotherapy. Therefore, the number of cases in the data base was not truly representative of the actual population of chemotherapy cases, which was therefore responsible for the low weighting factor.

Response: If a case is coded with cancer as the principal diagnosis, the claim would be paid in the appropriate DRG for the organ system in which the cancer occurred. Only cases for which chemotherapy is reported as the principal diagnosis are paid using the weighting factor for DRG 410. It would be extremely inappropriate for us to search out all cases in which chemotherapy was used for treatment of another principal diagnosis to be used in calculation of the weighing factor for DRG 410. We believe that the weighting factor for a particular DRG should be based exclusively on data from cases in that DRG relative to the average. We find no merit to the suggestion that the cost of chemotherapy in other DRGs be used for determining payment rates for DRG 410. Moreover, to the extent that the current weighting factor reflects coding practices that are no longer in use, the next recalibration of the DRG weights will reflect the relative resource intensity of cases as they were coded in the period from which the recalibration data base is drawn.

Comment: One commenter believes that our conclusions regarding DRGs 411 (History of Malignancy, Without Endoscopy) and 412 (History of Malignancy With Endoscopy) were based on erroneously coded data. He maintains that many hospitals did not routinely code endoscopies previously. He recommended a complete review of medical records should be initiated.

Response: If it is true that hospitals did not generally code endoscopic procedures in FY 1984, but have since modified coding, the data used in the next recalibration will reflect this. The weighting factors for DRGs 411 and 412, as for all other DRGs, were based upon the best data available at the time of the last recalibration. Any erroneous coding of data was beyond HCFA's control and will require further educational efforts on the part of coders, hospitals, and the PROs. Given the prospective nature of the prospective payment system, we do not believe it is necessary or appropriate to initiate a costly administrative review of the over 8,000 Medicare claims in these DRGs to verify if all endoscopic procedures were reported. Moreover, in light of the time period necessary to conduct such a review, it is quite likely that the next recalibration of the DRGs would take place simultaneously with or before such a review could be completed and the DRGs reweighted to correct for any coding errors.

M. MDC 20: Substance Use and Substance Induced Organic Mental Disorders

Comment: One commenter objected to the current policy regarding the exclusion of alcohol/drug hospitals and units. The commenter believes the current classification of the DRGs within MDC 20 has not been sufficiently tested. The commenter urged that the exclusion of alcohol/drug hospitals and units be extended until ProPAC has completed its evaluation of these DRGs.

Response: We addressed the issue of extension of the exclusion of alcohol/drug hospitals and units in the proposed rule setting forth changes to the prospective payment system for FY 1987. Readers are referred to that document for more information on our position in this regard.

N. MDC 23: Factors Influencing Health Status and Other Contacts with Health Services

Comment: One commenter believes that the alleged anomaly in the weighting factors for DRGs 465 (Aftercare With History of Malignancy as Secondary Diagnosis) and 466 (Aftercare Without History of Malignancy as Secondary Diagnosis) is due to coding errors.

Response: As with the responses to several previous comments, we do not believe it is necessary or appropriate to retrospectively review medical records of the claims in our data base to seek out coding omissions. A sample of Medicare claims are reviewed currently for DRG validity and coding accuracy. We believe review of current claims is more productive and valuable as an educational tool for PROs to identify and hospitals to correct coding problems. We simply do not have administrative funds available to intensively review medical records that are nearly 2 years old to test this commenter's hypothesis. As hospitals continue to improve coding of Medicare claims, the quality of program data on which future recalibrations are based will be superior, and the revised weighting factors in the future will reflect these differences. We will continue to work with the industry to educate medical records personnel on the importance of accurate, consistent and complete coding.

O. DRG 468: Unrelated OR Procedure

Comment: One commenter agreed with our decision not to establish a separate new technology DRG. However, the commenter urged that we develop an effective mechanism to respond to new technology more swiftly.

Response: We agree that it is important to respond to changing technologies promptly. We believe the establishment of the ICD–9–CM Coordination and Maintenance Committee will significantly contribute to our ability to be able to identify and gather necessary data on new technologies. In addition, we are considering the development of an administrative mechanism for ICD–9–CM procedure codes that would provide for more rapid recognition of new technologies. Once these processes are in place, we expect our ability to reflect new technologies in DRG assignment will be much more timely than in the past.

Comment: One commenter disagreed with our classification of lymphangioma and supported separate classification for lymphangioma and excision of lymphatic structure so that cases involving both would group to DRG 468. He said that current classification of the diagnosis does not take into account the location or complexity of the lymphangioma.

Response: We and other commenters continue to believe that lymphangioma treated surgically with excision of lymphatic structures should not be assigned to DRG 468. This DRG is appropriate only where none of the surgical procedures is related to the principal diagnosis. Clearly, excision of a lymphatic structure is related to treatment of lymphangioma in many cases, and, therefore, the treatment of this diagnosis with this procedure should not result in DRG 468 assignment.

Comment: One commenter supported an earlier comment pertaining to assignment of all pacemaker implants to DRG 115 or 116 rather than to DRG 468, regardless of the principal diagnosis. This commenter believes that continuing to assign pacemaker procedures to DRG 468 will adversely affect quality of care.

Response: As pointed out earlier, the fundamental principal of the DRG system is classification based on principal diagnosis. We do not believe it is appropriate to make an exception to this basic premise. In addition, we must point out that, while there is a substantial difference between the weighting factors for DRGs 115 and 468, the difference between the weighting factors for DRGs 116 and 468 is considerably smaller (.5167). Given the availability of outlier payments and the relatively low frequency of cardiac pacemaker cases assigned to DRG 468, we do not believe this decision will adversely affect the quality of services available.

Comment: One commenter stated that due to the enormous costs of transplants, the limited number of facilities performing them, and the realities of potential rejections, HCFA should develop a classification which accurately reflects the cost of performing re-transplants.

Response: We are continuing to study the impact of the DRG classification system on transplants and re-transplants. Until our analysis is completed we believe the current classification is an appropriate interim mechanism. If the results of our study indicate revision is necessary, changes will be proposed in the **Federal Register** for public comment.

Comment: One commenter disagreed with our decision not to include procedure code 8699 (Other operations on skin and substaneous tissue, not otherwise specified) as an O.R. procedure. He stated that "if procedure code 8699 must be used to describe any procedure that must be performed in an O.R., then the GROUPER must recognize this code as a valid O.R. procedure."

Response: The issue at hand is whether the case should be classified to a surgical DRG based on procedure code 8699 when no operating room procedure occurred. We continue to believe that, due to the variability in procedures coded as 8699, it is inappropriate to classify this an operating room procedure. As we have indicated elsewhere, we are working to develop an administrative approach that would permit us to further distinguish many types of procedures or approaches when several are identified by the same ICD–9–CM code.

V. Comments and Responses on New Coverage Decision

Comment: Six comments were received concerning our interim classification of Automatic Implantable Cardioverter—Defibrillators (AICDs). All commenters urged that classification to a lower weighted DRG not be considered. In addition, three commenters supported the creation of a new DRG exclusively for AICD.

Response: In the absence of a significant volume of claims data, we have decided to maintain classification of implantation of total system AICD cases to DRG 104 for Federal fiscal year 1987. A unique ICD–9–CM procedure code has been assigned to this procedure (see section VI) and appropriate GROUPER changes will be made to allow for the routine claims processing and data collection of such cases. We continue to be concerned with the appropriateness of

classification of this procedure into DRG 104. Once we have gathered sufficient Medicare data on this procedure, we will re-evaluate classification of this procedure. If the data indicate that DRG 104 classification is not appropriate, we will reclassify AICD cases as soon as practicable.

ProPAC had also recommended the creation of a new DRG devoted exclusively to AICD cases. We do not believe there is sufficient Medicare data as yet to permit appropriate evaluation of this proposal. We will consider this suggestion more fully in the future. For a more detailed explanation of our position in this regard, see our response to ProPAC comments in the proposed rule on prospective payment rates and changes for FY 1987.

VI. Comments and Responses on New Coding Changes

Comment: Two commenters objected to our decision not to publish precise ICD–9–CM rubrics for new codes for public comment. The commenters believe that, since new codes may ultimately contribute to DRG refinement, the codes should be subject to comment. One commenter also believes such a comment period would contribute to maintaining consistency and integrity of the coding system.

Response: We do not agree that it is necessary to publish the precise ICD–9–CM rubric for new codes for public comment. All proposed new ICD–9–CM codes are discussed at length in a public meeting of the ICD–9–CM Coordination and Maintenance Committee. The meetings are announced in the **Federal Register** and all interested members of the public are invited to submit agenda items, written comments and to attend the meeting.

Each past meeting has been attended by staff from ProPAC, the American Medical Records Association, the American Hospital Association, the Commission on Professional and Hospital Activities, as well as many other private parties. All comments presented, both oral and written, are considered by the Committee. We believe this process permits adequate opportunity for public input into the development of new ICD–9–CM codes.

In addition, the general areas for which new codes are being considered have been announced in the proposed notice of DRG classification changes. Further public comment on specific topics could be, and, in fact, was submitted for consideration at that time. In light of the fact that no DRG classification or payment changes are proposed, we do not feel it is essential to identify proposed ICD–9–CM rubrics in order to meet our commitment to the public of adequate notice and opportunity for suggestions. If, once the new codes are in use and data are available, we believe DRG refinement or classification change is appropriate, the proposed change will be published for review and comment in accordance with the procedures in § 412.10 of the regulations.

Comment: One commenter noted our statement that there are no explicit instructions or guidelines on coding bilateral procedures. The commenter suggested that we initiate action to establish such guidelines.

Response: As we also pointed out in the same discussion of coding bilateral procedures, it appears from review of claims data that the major portion of hospitals are coding the same procedure twice to indicate bilateral procedures. Consequently, we do not believe that in general hospitals are having difficulty coding bilateral procedures. Thus, this topic does not appear to represent a serious coding issue. Nonetheless, we have referred the commenter's recommendation to the ICD–9–CM Coordination and Maintenance Committee for consideration.

Comment: One commenter noted that new ICD–9–CM codes were proposed for cochlear prosthetic device implants. The commenter suggested specific ICD–9–CM rubrics and descriptions for appropriate identification of cochlear implants. He was particularly concerned that the new codes distinguish between single-channel and multi-channel devices.

Response: We share the commenter's concern that the new ICD–9–CM codes for cochlear prosthetic device implants adequately differentiate procedures with significant differences in resource utilization. The new codes for this procedure, as set forth below, allow for the identification of single, dual and not otherwise specified channel cochlear implants.

Comment: One commenter objected to the coding guideline that prohibits coding of surgical approaches. The commenter believes that coding of the surgical approach is often necessary to describe the procedure factually on the claim form to the Peer Review Organization (PRO). She specifically cited craniotomy and arthrotomy as issues.

Response: Volume 3 of the ICD–9–CM specifically directs that both arthrotomy (code 8016) and craniotomy (code 0124) not be coded when used as an operative approach. We do not believe the failure to code operative approaches in accordance with coding conventions interferes with appropriate PRO review of claims. The PROs have access to the medical records of patients in reviewing cases. The medical record should contain adequate information to allow the PROs to make appropriate determinations as to the medical necessity of the admission. In this regard, we would point out that the operative approach would be identified in the operating room report.

In addition, we would point out that coding of procedures used as surgical approaches can result in inappropriate DRG classification. For example, the coding of craniotomy when used as a means of access to perform cranial vascular or nerve procedures would result in classification of such cases to DRG 1 or 3 (Craniotomy Except for Trauma, Age Greater Than 17, and Craniotomy Under Age 18, respectively). Since DRG weighting factors are determined from past cases classified into each DRG, a preponderance of less intensive procedures classified into DRG 1 due solely to the coding of surgical approaches would inappropriately drive down the weight for this DRG. The result might be grossly inadequate payment for more intensive cranial procedures classified into DRG 1 or 3.

VII. Changes To Be Effective October 1, 1986

We are retaining, with slight modification, the provisions of the proposed notice, as discussed in section II. of this document.

A. DRG Classification Changes Resulting From Comment Process

1. *MDC 4: Diseases and Disorders of the Respiratory System.* Diagnosis code 4828 (Bacterial pneumonia not elsewhere classified) is removed from DRGs 89 (Simple Pneumonia and Pleurisy, Age over 69 and/or C.C.), 90 (Simple Pneumonia and Pleurisy; Age 18–69 without C.C.) and 91 (Simple Pneumonia and Pleurisy; Age 0–17). Code 4828 is included in DRGs 79 (Respiratory Infections and Inflammations Age over 69 and/or C.C.), 80 (Respiratory Infections and Inflammations, Age 18–69 without C.C.), and 81 (Respiratory Infections and Inflammations. Age 0–17).

2. *MDC 5: Diseases and Disorders of the Circulatory System.* Open chest coronary angioplasty (procedure code 3603) is assigned to DRG 109 (cardiothoracic procedures without pump). This procedure had previously been assigned to DRG 109, but had been removed in the September 3, 1985 reclassification changes due to the inability to distinguish it from PTCA through ICD–9–CM coding. Unique ICD–

9–CM codes have now been approved to distinguish the procedures; therefore, it is appropriate that open chest coronary angioplasty performed without extracorporeal circulation be classified to DRG 109.

3. *MDC 13: Diseases and Disorders of the Female Reprodcutive System.* We have revised the surgical hierarchy of this MDC, and, as proposed, have reconfigured DRGs 353, 354, 355, 357, 353, 359, 360, 361, and 362 to increase homogeneity and thus more accurately reflect resource intensity of cases assigned to these DRGs.

Unilateral vulvectomy (procedure code 7161) and bilateral vulvectomy (procedure code 7162) are removed from DRG 353 (Pelvic Evisceration, Radical Hysterectomy and Vulvectomy). These procedures are now assigned to DRG 360 (Vagina, Cervix and Vulva Procedures).

We are reconfiguring DRGs 354, 355, 357, 358, and 359 as follows:

- Uterus and adnexa procedures (except for incisional tubal interruption: procedure codes 6631, 6632, 6639, and 6663) are moved to the same section of the surgical hierarchy for MDC 13 as non-radical hysterectomies are currently in, above reconstructive procedures.
- Cases involving non-radical hysterectomies, uterus and adnexa procedures are divided into those with a principal diagnosis of malignancy and those without.
- Cases with a principal diagnosis of malignancy are further subdivided.

—Those with ovarian and adnexal malignancies (diagnosis codes 1830, 1832, 1833, 1834, 1835, 1838, 1839, 1986 and 2362) will be assigned to the new DRG 357 (Non-Radical Hysterectomy, Uterus and Adnexa Procedures, for Ovarian and Adnexal Malignancy).

—Those cases with a principal diagnosis of malignancy except ovarian and adnexal malignancy will be split on age and complications/comorbidities, and will be assigned to the new DRGs 354 and 355 (Non-Radical Hysterectomy, Uterus and Adnexa Procedures for Malignancy Except Ovarian/Adnexal Malignancy; Age over 69 and/or C.C., and Age under 70 without C.C., respectively).

- Cases with a principal diagnosis of other than malignancy also are divided on age and complications/comorbidities, will be assigned to the new DRGs 358 and 359 (Non-Radical Hysterectomy, Uterus and Adnexa Procedures for Non-Malignancy; Age over 69 and/or C.C., and Age under 70 without C.C., respectively).

We also are modifying DRGs 361 and 362 as follows:

- The procedure codes for incisional tubal interruption (6631, 6632, 6639 and 6663) are moved from DRG 359 and the uterine and adnexa part of the hierarchy to the laparoscopy section of the hierarchy.
- Cases involving these surgical procedures or laparoscopy (code 5421), are assigned to DRG 361.
- Cases involving endoscopic tubal interruption (procedure codes 6621, 6622, and 6629) are moved below the D & C, conization and radioactive implant section of the surgical hierarchy and are assigned to new DRG 362 (Endoscopic Tubal Interruption).

In order to accomplish this reconfiguration, it was necessary to reorder the surgical hierarchy of MDC 13. The revised surgical hierarchy for MDC 13 is as follows:

- Pelvic evisceration, radical hysterectomy and radical vulvectomy (DRG 353);
- Uterus and adnexal procedures (DRG 354, 355, 357, 358 and 359);
- Reconstruction (DRG 358);
- Vagina, cervix and vulva (DRG 360);
- Laparoscopy and incisional tubal interruption (DRG 361);
- D and C, conization and radio-implant (DRG 363 and 364);
- Endoscopic tubal interruption (DRG 362); and
- Other female reproductive system operating room procedures (DRG 365).

4. MDC 20: Substance Use and Substance Induced Organic Mental Disorders. The titles of MDC 20 and DRGs 433 through 437 are revised. Wherever the term "substance" appears in those DRGs, the term "alcohol/drug" is substituted.

B. New Coverage Decisions

Effective for procedures performed on or after January 24, 1986, Medicare coverage was extended to implantation of cardiac defibrillators under certain circumstances. On an interim basis, we will assign this procedure to DRG 104 (Cardiac Valve Procedure with Pump and with Cardiac Catheter).

Discrete ICD–9–CM procedure codes for this new technology had not yet been adopted at the time of publication of the proposed notice, but the ICD–9–CM Coordination and Maintenance Committee now has adopted new ICD–9–CM procedure codes for the implantation of cardiac defibrillators. The new procedure codes will be incorporated into the GROUPER software and thus classified into the appropriate DRG for discharges occurring on or after October 1, 1986. For discharges prior to October 1, 1986, payment will be made for such claims only on a manual basis when accompanied by appropriate documentation.

C. New Coding Changes

The following new ICD–9–CM codes have been approved for use effective October 1, 1986.

Cochlear Prosthetic Device Implant

20.96 Implantation of cochlear prosthetic device, not otherwise specified
20.97 Implantation or replacement of chochlear prosthetic device, single channel
20.98 Implantation or replacement of cochlear prosthetic device, multiple channel

Removal of Coronary Artery Obstruction

36.00 Unspecified
36.01 Percutaneous transluminal coronary angioplasty (PTCA) without mention of thrombolytic agent
36.02 Percutaneous transluminal coronary angioplasty (PTCA) with thrombolytic agent
36.03 Open chest coronary angioplasty
36.04 Intracoronary thrombolytic infusion
36.09 Other specified

Cardioverter/Defibrillator

37.94 Implantation or replacement of cardioverter/defibrillator, total system
37.95 Implantation of cardioverter/defibrillator lead(s) only
37.96 Implantation of cardioverter/defibrillator pulse generator only
37.97 Replacement of cardioverter/defibrillator lead(s) only
37.98 Replacement of cardioverter/defibrillator pulse generator only

Resection of Vessel with Replacement

(removal of the section mark allows the following unique fourth digit subclassification)

38.44 Aorta, abdominal
38.45 Thoracic vessels

Percutaneous Nephrostomy

55.03 Percutaneous nephrostomy without mention of fragmentation
55.04 Percutaneous nephrostomy with fragmentation of stone

Artificial Urinary Sphincter Implant

59.93 Implantation of artificial urinary sphincter (AUS)

Extracorporeal shockwave lithotripsy (ESWL)

59.96 Extracorporeal shockwave lithotripsy (ESWL)

Penile Prostheses

64.95 Insertion or replacement of internal non-inflatable prosthesis of penis
64.97 Insertion or replacement of internal inflatable prosthesis of penis

Chemonucleolysis

80.50 Excision or destruction of intervertebral disc, not otherwise specified
80.51 Excision

80.52 Chemonucleolysis
80.59 Unspecified

Magnetic Resonance Imaging (MRI)

88.90 Unspecified
88.91 Magnetic resonance imaging of brain and brain stem
88.92 Magnetic resonance imaging of chest and myocardium
88.93 Magnetic resonance imaging of spinal canal and contents, cervical, thoracic, and lumbar
88.94 Magnetic resonance imaging of musculoskeletal
88.95 Magnetic resonance imaging of pelvis, prostate and bladder
88.99 Magnetic resonance imaging, other and unspecified sites

As we pointed out in the March 13, 1986 proposed rule, these new codes will not result in DRG classification changes. Consequently, these new codes will be classified into the same DRGs that the procedure is currently classified using the previous coding rubric. We note that magnetic resonance imaging is not considered an operating room procedure and, therefore, will not affect the DRG classification of a case.

In order to prevent the unwarranted delay of recognition of new codes by the Medicare program, we will modify the GROUPER program, to the extent feasible, to recognize any new ICD–9–CM codes adopted in the future by the ICD–9–CM Coordination and Maintenance Committee and, in most cases, to classify discharges with such codes initially in the same DRG as the previous coding assignment. That is, any coding changes adopted by the committee prior to July 1, 1986 will be included in the Medicare GROUPER program for Federal fiscal year 1987 (October 1986 through September 1987), but will not necessarily result in changes to the classification of cases using these new codes. (See the proposed notice of PPS changes for FY 1987 for a list of other diagnoses and procedures for which new ICD–9–CM codes are being considered.) Coding changes approved subsequent to July 1, 1986 will be accommodated in future revisions of the GROUPER program. We will consider interim revisions of the GROUPER to recognize new ICD–9–CM codes, should the volume of cases indicate it is appropriate. Because the use of most new ICD–9–CM codes will not result in DRG classification changes initially, the new codes will not be published for public comment. Of course, should reclassification become necessary, we stated we would follow the procedures set forth at § 412.10 of the regulations.

D. Effective Dates

The changes in DRG classification and adoption of new ICD–9–CM codes are effective for discharges occurring on or after October 1, 1986.

VIII. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for notices such as this if the implementation of the notice would meet the criteria of a "major rule". A notice would be considered a major rule if its implementation would be likely to result in:

(1) An annual effect on the economy of $100 million or more;

(2) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

(3) Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

These changes to the DRG classification system and GROUPER program will not meet any of these criteria. Therefore, a regulatory impact analysis is not required.

B. Regulatory Flexibility Act

We prepare and publish a regulatory flexibility analysis, consistent with the Regulatory Flexibility Act of 1980 (RFA) (5 U.S.C. 601 through 612), for notices such as this unless the Secretary certifies that implementation of the notice would not have a significant economic impact on a substantial number of small entities. We treat all hospitals under the prospective payment system as small entities for purposes of the RFA. Therefore, this notice clearly would affect a substantial number of small entities. However, it is our practice not to consider an economic impact on small entities to be significant unless their annual total costs or revenues would be increased or decreased by at least 3 percent. These changes to the DRG classification system and the GROUPER program would not have results meeting this threshold. Therefore, we have determined and the Secretary certifies that a regulatory flexibility analysis is unnecessary.

IX. Information Collection Requirements

This final rule contains no information collection requirements. Consequently, it does not need to be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.).

(Secs. 1102, 1871, and 1886(d)(4) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ww(d)(4)); 42 CFR 412.10)

(Catalog of Federal Domestic Assistance Program No. 13.774, Medicare-Supplementary Medical Insurance)

Dated: May 27, 1986

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: May 28, 1986.

Otis R. Bowen,

Secretary.

[FR Doc. 86–12288 Filed 5–29–86; 1:52 pm]
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federal register

Tuesday
June 3, 1986

Part V

Office of Science and Technology Policy

Proposed Model Federal Policy for Protection of Human Subjects; Response to the First Biennial Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; Notice

OFFICE OF SCIENCE AND TECHNOLOGY POLICY

Proposed Model Federal Policy for Protection of Human Subjects; Response to the First Biennial Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

AGENCY: Office of Science and Technology Policy, Executive Office of the President.

ACTION: Notice of proposed model policy for department/agency implementation.

SUMMARY: This Notice sets forth the Office of Science and Technology Policy response to the recommendations in the *First Biennial Report* of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. This response, made on behalf of all affected federal departments and agencies, is based on the work of the *Ad Hoc* Committee for the Protection of Human Research Subjects and further deliberations of the Interagency Human Subjects Coordinating Committee. The *First Biennial Report* was published in the **Federal Register** on March 29, 1982 (47 FR 13272–13305). Responses of the *Ad Hoc* Committee were reviewed by the Science Advisor to the President and, with some modifications, accepted by affected department and agency heads in May 1985. This Notice includes in response to the first and most important recommendation, a Model Federal Policy for the Protection of Human Research Subjects (Model Policy) involved in research conducted, supported or regulated by federal departments and agencies. The Notice also contains a list of departments and agencies that intend to adopt the Model Policy and describes what, if any, departures from the Model Policy departments and agencies propose to make at the time of their policy implementation in order to meet particular statutory requirements or program needs.

Public comment and that of the federal departments and agencies is requested on the Proposed Model Policy, proposed department and agency departures, and other aspects of this Notice. Based upon these comments, a Final Model Policy will be published in the **Federal Register.** Each department and agency will expeditiously and in a coordinated fashion promulgate the Final Model Policy through its normal procedures for implementing such policies, e.g., through publication of regulations in the **Federal Register.**

DATES: Comments must be received on or before August 4, 1986. The Interagency Human Subjects Coordinating Committee will consider these comments and refer them to the Office of Science and Technology Policy for use in development of a Final Model Policy and to departments and agencies for use in their policy implementation.

ADDRESSES FOR COMMENT AND FURTHER INFORMATION: Comments and requests for further information should be addressed to: Joan P. Porter, Staff Director, Interagency Committee for the Protection of Human Subjects, Building 31, Room 4B09, Bethesda, Maryland 20892 (301–496–7041). Please specify which recommendations or sections of the Model Policy to which the comments pertain.

John P. McTague,

Acting Director, Office of Science and Technology Policy.

SUPPLEMENTARY INFORMATION:

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Background

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research was established on November 9, 1978, by Pub. L. 95–622. One of the charges to the President's Commission was to report biennially to the President, the Congress, and appropriate federal departments and agencies on the protection of human subjects of biomedical and behavioral research. In carrying out that charge, the President's Commission was directed to conduct a review of the adequacy and uniformity (1) of the rules, policies, guideline, and regulations of all federal departments and agencies regarding the protection of human subjects of biomedical or behavioral research which such departments and agencies conduct or support, and (2) of the implementation of such rules, policies, guidelines, and regulations by such agencies, such review to include appropriate recommendations for legislation and administrative action.

In December 1981 the President's Commission issued its *First Biennial Report on the Adequacy and Uniformity of Federal Rules and Policies, and their Implementation, for the Protection of Human Subjects in Biomedical and Behavioral Research, Protecting Human Subjects.* In transmitting the Report to the President, Morris B. Abram, Chairman of the Commission noted:

> The Commission does not propose any major changes in the substance of the rules on human research, although a number of adjustments are recommended to recognize the flexibility needed by research institutions, particularly in responding to allegations of wrongdoing or other problems. We also propose a simple improvement in the reports filed by researchers, to provide information on the number of subjects and on any that are adversely affected by participation in a research project.
>
> The Commission does recommend one major organizational change, namely that a uniform core of regulations be adopted, based upon the present rules of the Department of Health and Human Services, and that HHS become the lead agency in this field. This consolidation would eliminate needless duplication in the rules of the 23 other Federal entities that support or regulate research, thereby simplifying both local compliance with the rules and Federal oversight of the system. Copies of this report are being sent to all affected Federal agencies, with a request for action, pursuant to the Commission's enabling legislation.

In accord with Pub. L. 95–622, each federal department or agency which receives recommendations from the President's Commission with respect to its rules, policies, guidelines or regulations, must publish the recommendations in the **Federal Register** and provide an opportunity for interested persons to submit written data, views and arguments with respect to adoption of the recommendations. On March 29 1982, (47 FR 13272–13305) the Secretary, HHS, published the report on behalf of all the departments and agencies affected by the recommendations.

In May 1982 the Chairman of the Federal Coordinating Council for Science, Engineering and Technology (FCCSET), appointed an *Ad Hoc* Committee for the Protection of Human Research Subjects under the auspices of the FCCSET. The Committee, chaired by Dr. Edward N. Brandt, Jr., Assistant Secretary for Health, HHS, was composed of the representatives and *Ex Officio* members of affected departments and agencies. In consultation with the Office of Science and Technology Policy (OSTP) and the Office of Management and Budget, the *Ad Hoc* Committee, after considering all public comments, developed responses to the recommendations of the President's Commission. After further review and refinement, OSTP responded on behalf of all affected department and agency heads to the recommendations of the President's Commission.

The first and most far-reaching recommendation of the President's Commission resulted in the development of a Proposed Model Federal Policy for the Protection of Human Research Subjects based on the January 1981 HHS regulations for the protection of human subjects (45 CFR Part 46):

The President should, through appropriate action, require that all federal departments and agencies adopt as a common core the regulations governing research with human subjects issued by the Department of Health and Human Services (codified at 45 CFR Part 46), as periodically amended or revised, while permitting additions needed by any department or agency that are not inconsistent with these core provisions.

The *Ad Hoc* Committee agreed that uniformity is desirable among departments and agencies to eliminate unnecessary regulation and to promote increased understanding and ease of compliance by institutions that conduct federally supported or regulated research involving human subjects. Therefore, the *Ad Hoc* Committee developed a Model Policy, which applies to research involving human subjects that is conducted, supported or regulated by federal departments and agencies. In accordance with the Commission's recommendation, the Model Policy is based on Subpart A of the regulations of the Department of Health and Human Services (HHS) for the protection of human research subjects (45 CFR Part 46). The Proposed Model Policy developed by the *Ad Hoc* Committee was later modified by OSTP to enhance uniformity of implementation among the affected federal departments and agencies and to provide consistency with other related policies. The revised Policy was concurred in by all affected federal departments and agencies heads in March 1985.

The President's Commission also recommended that the President authorize and direct the Secretary, HHS, to designate an office with governmentwide jurisdiction to coordinate, monitor and evaluate the implementation of all federal regulations governing research with human subjects. For the reasons set forth in its response, the *Ad Hoc* Committee recommended that the Office for Protection from Research Risks (OPRR), National Institutes of Health, serve in a federal coordinating role for the protection of human subjects. The Director, OPRR, chairs the Interagency Human Subjects Coordinating Committee described below.

The Proposed Model Policy and the other responses to the President's Commission accepted by OSTP and the affected department and agency heads, are set forth below. After a public comment period and publication of a Final Model Policy, each department and agency will promulgate the Model Policy expeditiously through whatever procedures are normally utilized for the implementation of policies or regulations, e.g. through publication as regulations in the **Federal Register.** Instances in which the policies of certain departments and agencies propose to depart from the Model Policy during their rulemaking or other implementation processes to accommodate statutory or program requirements are also described herein.

The Interagency Human Subjects Coordinating Committee chartered in October 1983 under the auspices of FCCSET, is composed of representatives of all federal departments and agencies that conduct, support or regulate research involving human subjects. The Committee is advisory to department and agency heads, and among other responsibilities, evaluates the implementation of the Model Policy and recommends changes as necessary. OSTP responses to the recommendations of the President's Commission based on the report of the *Ad Hoc* Committee; the Proposed Model Policy; and the concurrences and intended departures of each affected federal department or agency head are presented below.

Response to Recommendations of the President's Commission

Response of the Office of Science and Technology Policy (OSTP) to the recommendations of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in *Protecting Human Subjects; the First Biennial Report on the Adequacy and Uniformity of Federal Rules and Policies, and their Implementation for the Protection of Human Subjects in Biomedical and Behavioral Research* (December 1981).

This response is based on the work of the *Ad Hoc* Committee for the Protection of Human Research Subjects of the Federal Coordinating Council for Science, Engineering, and Technology which was modified to incorporate OSTP policy considerations in and accepted by affected Federal department and agency heads in June 1984.

Recommendation 1

The President should, through appropriate action, require that all federal departments or agencies adopt as a common core the regulations governing research with human subjects issued by the Department of Health and Human Services (codified at 45 CFR Part 46), as periodically amended or revised, while permitting additions needed by any department or agency that are not inconsistent with these core provisions.

(A timetable of 180 days should be established by the President to provide an incentive for the interagency group to resolve any remaining questions about the HHS core regulations and identify an initial set of special rules beyond the core that are needed by various departments and agencies. If action is not prompt, the Commission suggests that Congress enact legislation directing the Executive branch to establish by a specified date a uniform set of regulations under a lead agency.)

The *Ad Hoc* Committee agreed in principle with this recommendation and developed a Model Federal Policy (Model Policy) statement based upon adaptations of HHS regulations for the protection of human subjects involved in research (45 CFR Part 46). The Office of Science and Technology Policy has made several modifications to increase uniformity of procedures among the federal departments and agencies and to increase compatibility with other current federal policies.

The Model Policy represented the *Ad Hoc* Committee's attempt to meet the concerns of the Commission that unnecessary and confusing regulations impose burdens on institutions that conduct or support research involving human subjects. The Committee attempted to make the Model Policy consistent with the HHS regulations while allowing for flexibility and adaptability in its application to the programs of diverse federal departments and agencies.

The *Ad Hoc* Committee believed that, insofar as possible, federal departments and agencies should employ consistent policies and procedures in dealing with nonfederal research institutions. Accordingly, the Model Policy was drafted in a mode that strives for uniformity in assurance and certification procedures; in all matters pertaining to the establishment, membership, functions and responsibilities of Institutional Review Board (IRBs); and in procedural requirements including informed consent. Nevertheless, the Model Policy will allow agencies to continue to utilize time-tested directives and procedures in the conduct of their intramural research so long as these procedures are consistent with the Model Policy and adequately protect the rights and welfare of human research subjects.

Similarly, the Policy is designed to apply to research conducted, supported or regulated by United States departments or agencies in foreign situations. However, department or agency heads may accept other recognized standards in lieu of this Policy so long as these standards offer at least equivalent protections for research subjects.

The *Ad Hoc* Committee concurred with the findings of the President's Commission that there is already close correlation between the major provisions of the HHS regulations and current policies and procedures of other federal departments and agencies for protecting human subjects. The Model Policy is intended to further reduce the diversity so that nonfederal research institutions will not have to face inconsistent or contradictory requirements in their dealings with federal departments and agencies. The *Ad Hoc* Committee fully expected that adoption of the Policy will reduce the administrative burdens on institutions that conduct research involving human subjects.

The Model Policy document has been drafted in the form of a policy statement rather than in the form of a regulation so that it may be referenced by departments and agencies that will implement the Policy within a reasonable time and in a manner customary to each department or agency. In the future, department or agency heads may amend their policies so long as they note in advance in the **Federal Register** or other appropriate publications the way in which their amendments relate to provisions of the Model Policy.

Assuming a department or agency adopts the Model Policy it will retain the flexibility to waive individual requirements if waiver decisions are published in advance in the **Federal Register** or other appropriate publication. The *Ad Hoc* Committee believed that instances of waiver will be infrequent, and the requirement that each waiver be published will prevent inappropriate use of the waiver authority.

Highlights of key elements of the Model Policy for federalwide use are as follows:

Consistency with HHS Regulations

As noted previously, the *Ad Hoc* Committee Model Policy is patterned after HHS regulations. The word "Secretary" has been changed to "department or agency head" throughout the draft. Most of the provisions of the following subject areas are the same in the Model Policy and HHS regulations:

(1) The characteristics of IRBs; (2) the role of IRBs in providing prior review of research protocols, including their duties and authorities in relation to investigators, to their institutions, and to the sponsors of research; (3) the standards and procedures that should govern IRB decision making and investigators' behavior; (4) the provisons of assuring compliance with the policy; (5) the procedures for expedited review; (6) the the provisions for obtaining and documenting informed consent; and (7) the provisions for early termination of research support and evaluation of applications. The following highlights the major areas in which there is a difference in the Model Policy and Current HHS regulations.

Applicability

Sec. 101(a) specifies that

. . . .[The policy] includes research conducted, supported, or otherwise subject to regulation by the federal government outside the United States.

(1) Research that is conducted or supported by a federal department or agency whether or not it is regulated as defined in Sec. 102(e) must comply with all sections of this policy.

(2) Research that is neither conducted nor supported by a federal department or agency but is subject to regulation as defined in Sec. 102(e) must be reviewed and approved, in compliance with Secs. 101, 102 and 107 through 117 of this policy, by an institutional review board (IRB) that operates in accordance with the pertinent requirements of this policy.

It should be noted that federal support of an activity does not necessarily render the policy applicable to that activity. Federal "support" must be used in "research" involving "human subjects" as defined in the policy. For example, a private physician who conducts research unrelated to the Medicaid program would not come under this policy solely because the sevices he/she provides some of his/her patients are reimbursed by Medicaid. Nor would a research project sponsored by a State agency be covered solely because nonresearch services administered by the same agency are federally reimbursed. Alternatively, if a privat physician or a State agency does employ federal support for research involving human subjects or if the physician or State agency voluntarily adopt this policy through the assurance mechanism, this policy would be applicable.

The Model Policy contains a definition of regulated research and indicates which sections of the policy are applicable to regulated research.

Sec. 102(e) defines regulated research.

'Research subject to regulation.' and similar terms are intended to encompass those research activities for which a federal department or agency has specific responsibility for regulating as a research activity, (for example, Investigational New Drug requirements administered by the Food and Drug Administration). It does not include research activities which are incidentally regulated by a federal department or agency solely as part of the department's or agency broader responsibility to regulate certain types of activities whether research or non-research in nature (for example, Wage and Hour requirements administered by the Department of Labor).

The provision in the HHS regulations which allows the Secretary to waive certain provisions is adapted to the Model Policy in the following manner:

Sec. 101(i) provides that

Unless otherwise required by law, department or agency heads may waive the applicability of some or all of the provisions of this policy to specific research activities or classes of research activities otherwise covered by this policy. Except when otherwise required by statute or Executive Order, the department or agency head shall forward advance notices of these actions to the Office for Protection from Research Risks, Department of Health and Human Services (HHS), and shall also publish them in the **Federal Register** or in such other manner as provided in department or agency procedures.

Consequently, waiver determinations must normally be published in the **Federal Register,** thus subjecting them to public scrutiny.

Changes in Exemptions

Sec. 101(b) sets forth exemptions for certain research activities from coverage of the Model Policy. The Model Policy combines exemptions 45 CFR 46.101(b)(2),(3) and (4) of the HHS regulations dealing with the use of educational tests, survey and interview procedures and observation of public behavior. The HHS exemptions are reflected in Model Policy exemptions sec. 101(b)(2) and (3):

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:

(1) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and

(ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing or employablity.

(3) Research involving the use of educational tests (cognitive, diagnostic. aptitude, achievement), survey procedures,

interview procedures or observation of public behavior that is exempt under paragraph (2), if:

(i) the human subjects are elected or appointed public officials or candidates for public office; or

(ii) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

Thus, provision is made in the Model Policy for exempting certain social secience research when federal statutes require without exception that the confidentiality of the personally identifiable information will be maintained.

Sec. 101(b)(6) is a new exemption

Taste and food quality evaluation studies, if wholesome foods without chemical additive are consumed or if a limited amount of a food is consumed that contains a food additive or agricultural chemical at or below a level approved by the Food and Drug Administration, the Environmental Protection Agency, or the Animal Plant Health Inspection Service of the U.S. Department of Agriculture.

This exemption, requested by the U.S. Department of Agriculture (USDA) but appropriate for several other agencies as well, is intended to exempt certain taste and food quality evaluation studies from IRB review. The current USDA policy exempts taste and food quality evaluation studies which involve consumer acceptance testing and quality evaluation studies if a limited amount of food will be consumed containing a food additive or agricultural chemical at a level approved by the Food and Drug Administration (FDA), the Environmental Protection Agency (EPA) or the Animal Plant Health Inspection Service (APHIS) of the USDA; or if the food chemical is normally found in food at concentrations at least equal to those being tested. The exemption is not intended to apply to task tests and quality evaluation studies if the food additive is being tested and the test chemical is *not* (1) on FDA's Generally Recognized as Safe (GRAS) list; (2) a permitted food additive as tested; or (3) normally found in food at concentrations being tested. In addition, the exemption is not intended to apply if a pesticide or other chemical residue is present and the acceptable level has not been established by FDA, EPA or APHIS.

Foreign Research

Sec. 101(g) states clearly what is only implicit in the HHS regulations, namely that the Model Policy does not affect any foreign laws or regulations which may otherwise be applicable and which provide additional protections for human subjects. Furthermore, it allows department and agency heads discretion in accepting equivalent procedures for research carried out in foreign countries.

Sec. 101(h) provides that

When research covered by this policy takes place in foreign countries, procedures normally followed in the foreign countries to protect human subjects may differ from those set forth in this policy. [An example is a foreign institution which complies with guidelines consistent with the 1975 World Medical Assembly Declaration (Helsinki II) issued either by sovereign states or by an organization whose function for the protection of human research subjects is internationally recognized.] In these circumstances, if a department or agency head determines that the procedures prescribed by the institution afford protections *that are at least equivalent* to those provided in this policy, the department or agency head may approve the substitution of the foreign procedures in lieu of the procedural requirements provided in this policy. Except when otherwise required by statute, Executive Order, or the department or agency head, notices of these actions as they occur will be published in the **Federal Register** or such other publications as provided by department or agency procedures. (Italics supplied)

Assuring Compliance with the Model Policy

Sec. 103(a) requires that

Each institution engaged in research which is covered by this policy and which is conducted or supported by a federal department or agency shall provide written assurance satisfactory to the department or agency head that it will comply with the requirements set forth in this policy.

Current HHS regulations permit institutions which hold an approved assurance to delay submission of certification of IRB review and approval until 60 days after submission of an application or proposal for financial support. The Model Policy does not include a grace period.

Sec. 103(g) requires that

Certification is required when the research is supported by a federal department or agency and not otherwise exempted or waived under Secs. 101(b) or (i). Along with the submission of an application or proposal for approval or support, an institution with an approved assurance covering the research shall certify that the application or proposal has been reviewed and approved by the IRB. Institutions without an approved assurance covering the research shall certify within 30 days after receipt of a request for such a certification from the department or agency, that the application or proposal has been approved by the IRB. If the certification is not submitted within these time limits, the application or proposal may be returned to the institution.

IRB Membership

Sec. 107(a) includes a provision that

. . . The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. . . .

Sec. 107(a) of the Model Policy also replaces the current HHS requirement that if an IRB regularly reviews research that involves a vulnerable category of subjects, the IRB must include one or more individuals who are primarily concerned with the welfare of those subjects. Consideration of inclusion of such an individual(s) is left to the institution (or other authority) establishing the IRB in the Model Policy.

The Model Policy requires instead in 107(a) that

. . . If an IRB regularly reviews research that involves a vulnerable category of subjects, such as children, prisoners, pregnant women or mentally disabled persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects.

45 CFR 46.107(b) of the 1981 HHS regulations indicates that no IRB may consist entirely of men or entirely of women, or entirely of members of one profession.

Section 107(b) of the Model Policy reads

Every nondiscriminatory effort will be made to ensure that no IRB consists entirely of men or entirely of women, including the institution's consideration of qualified persons of both sexes, so long as no selection is made to the IRB on the basis of gender. No IRB may consist entirely of members of one profession.

This language was developed in consultation with the Department of Justice.

In seeking diverse membership on the IRB, the institution must consider both men and women who can contribute to the work of the IRB. Given the ready availability of well qualified persons of both genders, OSTP expects that only rarely, if ever, will an IRB consist solely of men or solely of women. In any event, no selection shall be made to the board on the basis of gender.

Recommendation 2

The President should authorize and direct the Secretary of Health and Human Services to designate an office with government-wide jurisdiction to coordinate, monitor and evaluate the implementation of all regulations governing research with human subjects

of Federal departments that conduct, support or regulate such research.

The *Ad Hoc* Committee endorsed the concept of the designation of an office to coordinate the implementation of the Model Policy developed under Recommendation 1. However, the *Ad Hoc* Committee did not believe that it is either necessary or useful to assign the coordinating office "government-wide jurisdiction to *monitor* and *evaluate* the implementation of *all* regulations governing research with human subjects." For example, the Food and Drug Administration (FDA) has jurisdiction over nearly 30 different categories of test articles—each covered by appropriate regulations governing clinical research. It would be entirely impractical to expect a central HHS office to monitor and evaluate each of these specialized regulations, but it is feasible and desirable that rules governing IRB review and informed consent be consistent throughout all of these regulations and consistent with procedures required by other departments and agencies. As the President's Commission notes, most departments and agencies already follow the HHS rules pertaining to IRBs and informed consent. To date, uniformity has been developing on a voluntary basis with assistance from OPRR.

Reporting Requirements for Institutions

In consideration of Recommendations 7 and 8 in the *Biennial Report*, language has been included in Sec. 103(b)(5) to indicate that assurances negotiated with supporting federal agencies or departments must specify

> Written procedures for ensuring prompt reporting the IRB, appropriate institutional officials, and the department or agency head (i) any unanticipated problems or scientific misconduct involving risks to human subjects or others; (ii) any allegation or finding of serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and (iii) any suspension or termination of IRB approval.

This sets forth the requirement that all concerned parties be informed of problems and misconduct based on noncompliance with the Policy for the protection of human subjects. It allows research institutions flexibility in developing procedures compatible with their organizational structures, while requiring them to meet a reasonable standard of accountability. (See discussion of Recommendations 7 and 8, following.)

Role of the Office for Protection from Research Risks (OPRR)

In anticipation of designation of OPRR as a key coordinating office (described below in the *Ad Hoc* Committee's response to Recommendation 2), the following responsibility for OPRR has been made explicit in the Model Policy.

Sec. 103(f) requires that

> In lieu of negotiating a separate assurance, individual department or agency heads shall accept the existence of a current assurance, appropriate for the research in question, approved by and on file with the Office for Protection from Research Risks, HHS.

This provision will considerably reduce the administrative burden on institutions conducting research and on federal departments and agencies conducting or supporting research.

The *Ad Hoc* Committee, therefore, recommended that the President's Science Advisor request the Secretary, HHS, to direct the OPRR to exercise federalwide coordination of policies and procedures for the protection of human research subjects. The Model Policy has been drafted to reflect an OPRR role.

The coordinating responsibilities of OPRR include at least the following:

(1) OPRR shall continue to negotiate and approve Assurances of Compliance with the HHS regulations based on the Model Policy for HHS conducted and supported research. In lieu of negotiating a separate assurance, individual departments and agencies shall accept a current HHS assurance approved by and on file in OPRR if it is appropriate to the research in question.

(2) OPRR shall facilitate an exchange of information among all federal departments and agencies that conduct, support or regulate research involving human subjects.

(3) OPRR shall, when appropriate, amend and republish the list of categories of research that may be reviewed under the expedited procedures outlined under Sec. 110 of the Model Policy.

(4) OPRR shall continue to develop educational materials and programs for the benefit of (a) research investigators; (b) research administrators; (c) IRB members; and (d) federal officials with responsibility for research involving human subjects.

(5) Department and agency heads shall forward to OPRR for review and comment all proposed department or agency policies and regulations for the protection of human research subjects. OPRR shall within 90 days of receipt call to the attention of any department or agency issuing a proposed rule or policy any provisions inconsistent with the Model Policy.

(6) The Director, OPRR, shall chair an Interagency Human Subjects Coordinating Committee to facilitate coordination of federal policies and regulations for the protection of human subjects. (This Committee was established in October 1983 by the Director, OSTP, under the auspices of the Federal Coordinating Council for Science, Engineering and Technology and is advisory to department and agency heads.)

The *Ad Hoc* Committee believed that if these coordinating steps are taken (including advising, guiding, educating and reviewing as described), the purposes of the recommendations of the President's Commission will be accomplished. The Interagency Committee is well-positioned to evaluate the implementation of the Model Policy when necessary and appropriate.

The *Ad Hoc* Committee further believed that over many years the OPRR has established sound credentials in the protection of human subjects. It noted that OPRR has operated effectively with all necessary backing from the Office of the Secretary, HHS. Because OPRR is located in a research milieu, it has ready access to experts in biomedical and behavioral research with experience in dealing with the delicate balance of promoting high quality research while maintaining proper safeguards for human subjects.

By designating OPRR as the coordinating office, the *Ad Hoc* Committee believed that the Secretary, HHS, would give emphasis to the importance of the coordinating function to be exercised. Establishment of a permanent federalwide advisory group assures the continuation of this emphasis. By designating an existing office in HHS rather than creating a new office, the Secretary is able to accomplish the goals of the President's Commission with only minimal increases in monetary and personnel expenditures.

Recommendation 3

Each Federal department or agency should have a comprehensive set of rules and procedures governing research with human subjects that applies consistently to all submits within the department or agency.

No action required on Recommendation 3 will be needed if the procedures outlined in response to Recommendations 1 and 2 are adopted.

Recommendation 4

All Federal departments and agencies that conduct or support research with

human subjects should require principal investigators to submit, as part of their annual reports to the IRB and the funding agency, information regarding the number of subjects who participated in each research project as well as the nature and frequency of adverse effects.

The *Ad Hoc* Committee questioned the feasibility of developing a major data collection of numbers of human subjects who participate in Federally conducted or supported research. It acknowledged the importance of sound data relating to research injuries and adverse reactions and recognized such data would be helpful in making sound policy decisions concerning compensation for research injuries. Nevertheless, the *Ad Hoc* Committee recognized serious definitional problems associated with the collection of such data.

The President's Commission has acknowledged the difficulty in defining research-related injury. The Veterans Administration (VA) has made efforts to collect data of the type recommended by the President's Commission. The VA program, attempted as a pilot effort, has been fraught with technical difficulties.

The VA has described certain difficulties recently encountered in collecting data on human research subjects. The VA had issued circulars to its medical centers which were conducting research involving human subjects. The circulars requested that the centers collect data regarding the incidence of adverse results "or effects" of participation in biomedical and behavioral research. The collected data were forwarded to the central VA office. Figures received in November 1981 provided the VA with unreliable and incomplete reports of human subjects injured or otherwise adversely affected as the result of participation in research projects. Because of definitional problems, misunderstandings on the part of field research personnel, confounding of therapeutic and research data and instances of both underreporting and overreporting, the data were considered misleading or meaningless. The data were not amenable to synthesis.

Given the existing definitional problems and the expected poor quality of resulting data, the *Ad Hoc* Committee believed that the expenditure of scarce resources for data collection was not warranted at this time. In fact, implementation of this recommendation could produce results that are misleading and could generate inappropriate policies and procedures. Therefore, the *Ad Hoc* Committee recommended that the matter of data collection be addressed by an Interagency Human Subjects Coordinating Committee.

Recommendation 5

The Department of Health and Human Services and all other relevant Federal departments and agencies should proceed promptly to take action on the National Commission's recommendations concerning research involving children and research involving those institutions as mentally disabled, and other Federal agencies should also act on the final regulations of HHS governing such research. . . .

In early February 1983 HHS Secretary Schweiker approved Subpart D of Title 45 CFR Part 46, "Additional Protections for Children Involved as Subjects in Research." These were published as a Final Rule in the **Federal Register** on March 8, 1983, and became effective June 6, 1983. HHS is now considering action on the proposed regulations addressing research involving those institutionalized as mentally disabled.

Recommendation 6

Congress should attach the following condition to any direct appropriations for "private" research entities: "No funds appropriated under this Act may be used, directly or indirectly, to support research involving human subjects unless such research is reviewed and conducted in compliance with either (1) appropriate regulations of (the disbursing agency) or (2) the regulations of the Department of Health and Human Services (45 CFR Part 46)."

The *Ad Hoc* Committee was unaware of any "private" research entity which receives direct appropriations other than the Gorgas Memorial Institute of Tropical and Preventive Medicine, Inc. OPRR has negotiated an HHS Multiple Project Assurance of Compliance with Gorgas Memorial Institute which has indicated its intention to comply with HHS regulations. Consequently this recommendation has been met by administrative action, and no legislation is required. If other such entities are identified, the federal disbursing agency should arrange for a proper Assurance of Compliance with HHS or Model Policy requirements.

Recommendations 7 and 8

7. 45 CFR 46.103, which specifies the minimum requirements for an institutional assurance, should be amended by inserting two new clauses under (b) (5) and (6): to—

- *designate a specific office at each institution that will be responsible for: (i) receiving reports of alleged misconduct in research involving human subjects; (ii) investigating promptly and fairly; and (iii) reporting formal findings of misconduct both to the institution's IRB which approved the research and to the Secretary. The institutional office so designated need not be created specifically for this purpose but may be the relevant IRB itself or another existing office already having responsibility for quality assurance with the institution. Such office shall report on all ongoing investigations of alleged research misconduct involving human subjects as well as formal findings to the IRB, and shall consult with the IRB on all matters relating to the conduct of research with human subjects.* (paraphrased)
- *require written procedures for insuring prompt reporting to designated institutional officials, and by them to the Secretary, of the results of any investigation or inquiries carried out under the preceding subsection or under Sec. 46.108(c) that reveal research misconduct or serious or continuing noncompliance with Federal or institutional requirements for the protection of human subjects.* (paraphrased)

8. 45 CFR 46.108(c) should be revised to read as follows: (In order to fulfill the requirements of these regulations, each IRB shall) (c) be responsible for reporting to the appropriate institutional officials any serious or continuing noncompliance by investigators with the requirements and determinations of the IRB, or with the provisions of the regulations, or with good research practices, that is revealed during the IRB's continuing or annual review of research or through reports made directly to a member of the IRB or its staff (and that each IRB); (d) establish procedures for receiving and acting upon findings of misconduct in research involving human subjects, made in the office designated pursuant to Sec. 46.103(b)(5). (paraphrased)

After careful review of the recommendations of the President's Commission, the testimony to the Commissioners leading to these recommendations, and public and interagency comment, the *Ad Hoc* Committee proposed the following: *Sec. 103(b)(5)* of the proposed Model Policy requires that in assurances submitted to heads of departments or agencies conducting or supporting research involving human subjects institutions must include

Written procedures for ensuring prompt reporting to the IRB, appropriate institutional officials, and the department or agency head (i) any unanticipated problems or scientific misconduct involving risk to human subjects or others, (ii) any allegation or finding of

serious or continuing noncompliance with this policy or the requirements or determinations of the IRB, and (iii) any suspension or termination of IRB approval.

The *Ad Hoc* Committee concluded that addition of this language would permit deletion of the current 45 CFR 46.108(c) which states that an IRB ". . . be responsible for reporting to the appropriate institutional officials and the Secretary any serious or continuing noncompliance by investigators with the requirements and determination of the IRB."

By modification of current language in the HHS regulations, the *Ad Hoc* Committee believed that (a) any implication is eliminated that the IRB is required to be an investigatory and reporting body in the institution. Institutions may develop their own procedures to assure that allegations are promptly investigated and reported to appropriate institutional officials as well as to supporting federal department or agency officials, and (b) the establishment of reporting lines is assigned to the institutions; and groups which need to be informed are identified. Institutions are, therefore, afforded flexibility in meeting requirements of the Policy. The assurance is the appropriate document for identifying the specific offices to be notified and the timing and nature of reporting which may be tailored to each institution's organizational structure. The *Ad Hoc* Committee members noted that the language proposed in Recommendations 7 and 8 was perhaps too detailed for verbatim incorporation into the Model Policy.

Recommendation 9

Federal departments and agencies should establish government-wide procedures for making determinations on suspension and debarment of grantees and contractors alleged to have engaged in misconduct in Federally supported research with human subjects. Final determinations and sanctions imposed should be entered onto a consolidated list of individuals and made known to all Federal agencies involved with human research, to state licensing boards, and to appropriate professional societies.

The *Ad Hoc* Comment generally concurred with the recommendation for the establishment of government-wide procedures for making determinations on suspension and debarment of grantees and contractors alleged to have engaged in misconduct in federally-supported research with human subjects. However, the *Ad Hoc* Committee believed that this recommendation should be carried out as a part of an Executive Branch consideration of government-wide suspension and debarment procedures encompassing misconduct under all types of federal support.

The Executive Branch has undertaken several initiatives in this regard. With respect to contracts (i.e., procurement) the Office of Federal Procurement Policy on the OMB issued, on June 24, 1982, a Policy Letter setting forth government-wide policies and procedures for suspension and debarment of government contractors and for the establishment of a consolidated government-wide listing of these suspensions and debarments (47 FR 28854). The Policy Letter became effective on August 30, 1982, and the General Services Administration become responsible for maintaining the consolidated listing of suspensions and debarments of contractors on that date. The Policy Letter has now been incorporated in the Federal Acquisition Regulation (48 CFR Chapter 1) as Subpart 9.4, and on February 26, 1985 HHS published implementing procedures in 48 CFR 309.4.

With respect to grants and other forms of financial assistance (i.e., nonprocurement), on February 18, 1986, President Reagan signed Executive Order 12549 mandating the establishment, under the guidance of OMB, of a government-wide system for debarment and suspension from federal assistance programs. OMB published proposed Guidelines simultaneously with the Executive Order, which provided 60 days opportunity for comment. OMB is currently reviewing the comments and expects to publish the final Guidelines within six months. The Executive Order calls for implementing agency regulations within 12 months of the final OMB Guidelines. This will result in separate government-wide procedures for the suspension and debarment of contractors and of recipients of financial assistance. Although federally-supported research with human subjects is not specifically mentioned in the government-wide procedures, one or more of the specifically stated causes for suspension and debarment could arise in the course of such research. The Interagency Human Subjects Coordination Committee will monitor any suspension or debarment actions arising from research involving human subjects.

Model Federal Policy for Protection of Human Research Subjects

Sec. 101 To What Does This Policy Apply?

(a) Except as provided in paragraph (b) below, this policy applies to all research involving human subjects conducted, supported or otherwise subject to regulation by any federal department or agency which takes appropriate administrative action to make the policy applicable to such research. This includes research conducted by federal civilian employees or military personnel, except that each department or agency head may adopt such procedural modifications as may be appropriate from an administrative standpoint. It also includes research conducted, supported, or otherwise subject to regulation by the Federal government outside the United States.

(1) Research that is conducted or supported by a federal department or agency whether or not it is regulated as defined in Sec. 102(e) must comply with all sections of this policy.

(2) Research that is neither conducted nor supported by a federal department or agency but is subject to regulation as defined in Sec. 102(e) must be reviewed and approved, in compliance with Secs. 101, 102, and 107 through 117 of this policy, by an institutional review board

(IRB) that operates in accordance with the pertinent requirements of this policy.

(b) Unless otherwise required by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

(1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing or employability.

(3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior that is not exempt under paragraph (2), if: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

(4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

(5) Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service program; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

(6) Taste and food quality evaluation studies, if wholesome foods without chemical additives are consumed or if a limited amount of a food is consumed that contains a food additive or agricultural chemical at or below a level approved by the Food and Drug Administration, the Environmental Protection Agency, or the Animal Plant Health Inspection Service of the U.S. Department of Agriculture.

(c) Department or agency heads retain final judgment as to whether a particular activity is covered by this policy.

(d) Department or agency heads may require that specific research activities or classes of research activities conducted, supported, or otherwise subject to regulation by the department or agency but not otherwise covered by this policy, comply with some or all of the requirements of this policy.

(e) Compliance with this policy requires compliance with pertinent federal laws or regulations which provide additional protections for humans subjects.

(f) This policy does not affect any state or local laws or regulations which may otherwise be applicable and which provide additional protections for human subjects.

(g) This policy does not affect any foreign laws or regulations which may otherwise be applicable and which provide additional protections to human subjects of research.

(h) When research covered by this policy takes place in foreign countries; procedures normally followed in the foreign countries to protect human subjects may differ from those set forth in this policy. [An example is a foreign institution which complies with guidelines consistent with the 1975 World Medical Assembly Declaration (Helsinki II) issued either by sovereign states or by an organization whose function for the protection of human research subjects is internationally recognized.] In these circumstances, if a department or agency head determines that the procedures prescribed by the institution afford protections that are at least equivalent to those provided in this policy, the department or agency head may approve the substitution of the foreign procedures in lieu of the procedural requirements provided in this policy. Except when otherwise required by statute, Executive Order, or the department or agency head, notices of these actions as they occur will be published in the **Federal Register** or will be otherwise published as provided in department or agency procedures.

(i) Unless otherwise required by law, department or agency heads may waive the applicability of some or all of the provisions of this policy to specific research activities or classes of research activities otherwise covered by this policy. Except when otherwise required by statute or Executive Order, the department or agency head shall forward advance notices of these actions to the Office for Protection from Research Risks, Department of Health and Human Services (HHS), and shall also publish them in the **Federal Register** or in such other manner as provided in department or agency procedures.

Sec. 102 Definitions.

(a) "Department or agency head" means the head of any federal department or agency and any other officer or employee of any department or agency to whom authority has been delegated.

(b) "Institution" means any public or private entity or agency (including federal, state, and other agencies).

(c) "Legally authorized representative" means an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research.

(d) "Research" means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute "research" for purposes of this policy, whether or not they are conducted under a program which is considered research for other purposes. For example, some "demonstration" and "service" programs may include research activities.

(e) "Research subject to regulation," and similar terms are intended to encompass those research activities for which a federal department or agency has specific responsibility for regulating as a research activity, (for example, Investigational New Drug requirements administered by the Food and Drug Administration). It does not include research activities which are incidentally regulated by a federal department or agency solely as part of the department's or agency's broader responsibility to regulate certain types of activities whether research or non-research in nature (for example, Wage and Hour requirements administered by the Department of Labor).

(f) "Human subject" means a living individual about whom an investigator (whether professional or student)

conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information. "Intervention" includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. "Interaction" includes communication or interpersonal contact between investigator and subject. "Private information" includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

(g) "IRB approval" means the determination of the IRB that the research has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and by other institutional and federal requirements.

(h) "Minimal risk" means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

(i) "Certification" means the official notification by the institution to the supporting department or agency, in accordance with the requirements of this policy, that a research project or activity involving human subjects has been reviewed and approved by an IRB in accordance with an approved assurance.

Sec. 103 Assuring compliance with this Policy—research conducted or support by any Federal Department or Agency.

(a) Each institution engaged in research which is covered by this policy and which is conducted or supported by a federal department or agency shall provide written assurance satisfactory to the department or agency head that it will comply with the requirements set forth in this policy.

(b) Departments and agencies will conduct or support research covered by this policy only if the institution has an assurance approved as provided in this section, and only if the institution has certified to the department or agency head that the research has been reviewed and approved by an IRB provided for in the assurance, and will be subject to continuing review by the IRB. Assurances applicable to federally supported or conducted research shall at a minimum include:

(1) A statement of principles governing the institution in the discharge of its responsibilities for protecting the rights and welfare of human subjects of research conducted at or sponsored by the institution, regardless of whether the research is subject to federal regulation. This may include an appropriate existing code, declaration, or statement of ethical principles, or a statement formulated by the institution itself. This requirement does not preempt provisions of this policy applicable to department- or agency-supported or regulated research and need not be applicable to any research exempted or waived under Secs. 101 (b) or (i).

(2) Designation of one or more IRBs established in accordance with the requirements of this policy, and for which provisions are made for meeting space and sufficient staff to support the IRB's review and recordkeeping duties.

(3) A list of the IRB members identified by name; earned degrees; representative capacity; indications of experience such as board certifications, licenses, etc., sufficient to describe each member's chief anticipated contributions to IRB deliberations; and any employment or other relationship between each member and the institution; for example: full-time employee, part-time employee, member of governing panel or board, stockholder, paid or unpaid consultant. Changes in IRB membership shall be reported to the department or agency head.

(4) Written procedures which the IRB will follow (i) for conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and the institution; (ii) for determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review; and (iii) for ensuring prompt reporting to the IRB of proposed changes in a research activity, and for ensuring that such changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval except when necessary to eliminate apparent immediate hazards to the subject.

(5) Written procedures for ensuring prompt reporting to the IRB, appropriate institutional officials, and the department or agency head (i) any unanticipated problems or scientific misconduct involving risks to human subjects or others; (ii) any allegation or finding of serious or continuing noncompliance with this policy or the requirements or determinations of the IRB; and (iii) any suspension or termination of IRB approval.

(c) The assurance shall be executed by an individual authorized to act for the institution and to assume on behalf of the institution the obligations imposed by this policy and shall be filed in such form and manner as the department or agency head prescribes.

(d) The department or agency head will evaluate all assurances submitted in accordance with this policy through such officers and employees of the department or agency and such experts or consultants engaged for this purpose as the department or agency head determines to be appropriate. The department or agency head's evaluation will take into consideration the adequacy of the proposed IRB in light of the anticipated scope of the institution's research activities and the types of subject populations likely to be involved, the appropriateness of the proposed initial and continuing review procedures in light of the probable risks, and the size and complexity of the institution.

(e) On the basis of this evaluation, the department or agency head may approve or disapprove the assurance, or enter into negotiations to develop an approvable one. The department or agency head may limit the period during which any particular approved assurance or class of approved assurances shall remain effective or otherwise condition or restrict approval.

(f) In lieu of negotiating a separate assurance, individual department or agency heads shall accept the existence of a current assurance, appropriate for the research in question, approved by and on file with the Office for Protection from Research Risks, HHS.

(g) Certification is required when the research is supported by a federal department or agency and not otherwise exempted or waived under Secs. 101 (b) or (i). Along with the submission of an application or proposal for approval or support, an institution with an approved assurance covering the research shall certify that the application or proposal has been reviewed and approved by the IRB. Institutions without an approved assurance covering the research shall certify within 30 days after receipt of a

request for such a certification from the department or agency, that the application or proposal has been approved by the IRB. If the certification is not submitted within these time limits, the application or proposal may be returned to the institution.

Sec. 104 Section reserved.

Sec. 105 Section reserved.

Sec. 106 Section reserved.

Sec. 107 IRB Membership.

(a) Each IRB shall have at least five members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members, including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to possessing the professional competence necessary to review specific research activities, the IRB shall be able ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB shall therefore include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a vulnerable category of subjects, such as children, prisoners, pregnant women or mentally disabled persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects.

(b) Every nondiscriminatory effort will be made to ensure that no IRB consists entirely of men or entirely of women, including the institution's consideration of qualified persons of both sexes, so long as no selection is made to the IRB on the basis of gender. No IRB may consist entirely of members of one profession.

(c) Each IRB shall include at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.

(d) Each IRB shall include at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.

(e) No IRB may have a member participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB.

(f) An IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

Sec. 108 IRB functions and operations.

In order the fulfill the requirements of this policy each IRB shall:

(a) Follow written procedures in the same detail as described in Sec. 103(b)(4) and, to the extent required by, Sec. 103(b)(5).

(b) Except when an expedited review procedure is used (see Sec. 110), review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas. In order for the research to be approved, it shall receive the approval of a majority of those members present at the meeting.

Sec. 109 IRB review of research.

(a) An IRB shall review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by this policy.

(b) An IRB shall require that information given to subjects as part of informed consent is in accordance with Sec. 116. The IRB may require that information, in addition to that specifically mentioned in Sec. 116, be given to the subjects when in the IRB's judgment the information would meaningfully add to the protection of the rights and welfare of subjects.

(c) An IRB shall require documentation of informed consent or may waive documentation in accordance with Sec. 117.

(d) An IRB shall notify investigators and the institution in writing of its decision to approve or disapprove the proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.

(e) An IRB shall conduct continuing review of research covered by this policy at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research.

Sec. 110 Expedited review procedures for certain kinds of research involving no more than minimal risk, and for minor changes in approved research.

(a) The Secretary, HHS, has established, and published in the **Federal Register**, a list of categories of research that may be reviewed by the IRB through an expedited review procedure. The list will be amended, as appropriate after consultation with other departments and agencies, through periodic republication by the Secretary, HHS, in the **Federal Register.**

(b) With the approval of department or agency heads, an IRB may use the expedited review procedure to review either or both of the following: (1) Some or all of the research appearing on the list and found by the reviewers to involve no more than minimal risk, (2) minor changes in previously approved research during the period for which approval is authorized. Under an expedited review procedure, the review may be carried out by the IRB chairperson or by one or more experienced reviewers designated by the chairperson from among members of the IRB. In reviewing the research, the reviewers may exercise all of the authorities of the IRB except that the reviewers may not disapprove the research. A research activity may be disapproved only after review in accordance with the non-expedited procedure set forth in Sec. 108(b).

(c) Each IRB which uses an expedited review procedure shall adopt a method for keeping all members advised of research proposals which have been approved under the procedure.

(d) The department or agency head may restrict, suspend, terminate, or choose not to authorize an institution's or IRB's use of the expedited review procedure.

Sec. 111 Criteria for IRB approval of research.

(a) In order to approve research covered by this policy the IRB shall determine that all of the following requirements are satisfied:

(1) Risks to subjects are minimized: (i) By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

(2) Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks

and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge gained in the research (for example, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.

(3) Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in whch the research will be conducted and should be particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.

(4) Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by Sec. 116.

(5) Informed consent will be appropriately documented, in accordance with, and to the extent required by Sec. 117.

(6) When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.

(7) When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

(b) When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

Sec. 112 Review by institution.

Research covered by this policy that has been approved by an IRB may be subject to further appropriate review and approval or disapproval by officials of the institution. However, those officials may not approve the research if it has not been approved by an IRB.

Sec. 113 Suspension or termination of IRB approval of research.

An IRB shall have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and the department or agency head.

Sec. 114 Cooperative research.

Cooperative research projects are those projects covered by this policy which involve more than one institution. In the conduct of cooperative research projects, each instituation is responsible for safeguarding the rights and welfare of human subjects and for complying with this policy. With the approval of the department or agency head, an institution participating in a cooperative project may enter into a joint review arrangement, rely upon the review of another qualified IRB, or make similar arrangements for avoiding duplication of effort.

Sec. 115 IRB records.

(a) An institution, or when appropriate an IRB, shall prepare and maintain adequate documentation of IRB activities, including the following:

(1) Copies of all research proposals reviewed, scientific evaluations, if any, that accompany the proposals, approved sample consent documents, progress reports submitted by investigators, and reports of injuries to subjects.

(2) Minutes of IRB meetings which shall be in sufficient detail to show attendance at the meetings; actions taken by the IRB; the vote on these actions including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution.

(3) Records of continuing review activities.

(4) Copies of all correspondence between the IRB and the investigators.

(5) A list of IRB members in the same detail as described in Sec. 103(b)(3).

(6) Written procedures for the IRB in the same detail as described in Secs.103(b)(4) and 103(b)(5).

(7) Statements of significant new findings provided to subjects, as required by Sec. 116(b)(5).

(b) The records required by this policy shall be retained for at least 3 years, and records relating to research which is conducted shall be retained for at least 3 years after completion of the research. All records shall be accessible for inspection and copying by authorized representatives of the department or agency at reasonable times and in a reasonable manner.

Sec. 116 General requirements for informed consent.

Except as provided elsewhere in this policy, no investigator may involve a human being as a subject in research covered by this policy unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative. An investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The information that is given to the subject or the representative shall be in language understandable to the subject or the representative. No informed consent, whether oral or written, may include any exculpatory language through which the subject or the representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the institution or its agents from liability for negligence.

(a) Basic elements of informed consent. Except as provided in paragraph (c) or (d) below, in seeking informed consent the following information shall be provided to each subject:

(1) A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental;

(2) A description of any reasonably foreseeable risks or discomforts to the subject;

(3) A description of any benefits to the subject or to others which may reasonably be expected from the research;

(4) A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

(5) A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;

(6) For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;

(7) An explanation of whom to contact for answers to pertinent questions about

the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject; and

(8) A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

(b) Additional elements of informed consent. When appropriate, one or more of the following elements of information shall also be provided to each subject:

(1) A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) which are currently unforeseeable;

(2) Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent;

(3) Any additional costs to the subject that may result from participation in the research;

(4) The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;

(5) A statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will be provided to the subject; and

(6) The approximate number of subjects involved in the study.

(c) An IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent set forth above, or waive the requirement to obtain informed consent provided the IRB finds and documents that:

(1) The research or demonstration project is to be conducted by or subject to the approval of state or local government officials and is designed to study, evaluate, or otherwise examine: (i) Public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs; and

(2) The research could not practicably be carried out without the waiver or alteration.

(d) An IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent set forth above, or waive the requirements to obtain informed consent provided the IRB finds and documents that:

(1) The research involves no more than minimal risk to the subjects;

(2) The waiver or alteration will not adversely affect the rights and welfare of the subjects;

(3) The research could not practicably be carried out without the waiver or alteration; and

(4) Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

(e) The informed consent requirements in this policy are not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for informed consent to be legally effective.

(f) Nothing in this policy is intended to limit the authority of a physician to provide emergency medical care, to the extent the physician is permitted to do so under applicable federal, state, or local law.

Sec. 117 Documentation of informed consent.

(a) Except as provided in paragraph (c) below, informed consent shall be documented by the use of a written consent form approved by the IRB and signed by the subject or the subject's legally authorized representative. A copy shall be given to the persons signing the form.

(b) Except as provided in paragraph (c) below, the consent form may be either of the following:

(1) A written consent document that embodies the elements of informed consent required by Sec. 116. This form may be read to the subject or the subject's legally authorized representative, but in any event, the investigator shall give either the subject or the representative adequate opportunity to read it before it is signed; or

(2) A "short form" written consent document stating that the elements of informed consent required by Sec. 116 have been presented orally to the subject or the subject's legally authorized representative. When this method is used, there shall be a witness to the oral presentation. Also, the IRB shall approve a written summary of what is to be said to the subject or the representative. Only the short form itself is to be signed by the subject or the representative. However, the witness shall sign both the short form and a copy of the summary, and the person actually obtaining consent shall sign a copy of the summary. A copy of the summary shall be given to the subject or the representative, in addition to a copy of the "short form."

(c) An IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either:

(1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each suject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or

(2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

In cases in whch the documentation requirement is waived, the IRB may require the investigator to provide subjects with a written statement regarding the research.

Sec. 118 Applications and proposals lacking definite plans for involvement of human subjects.

Certain types of applications for grants, cooperative agreements, or contracts are submitted to departments or agencies with the knowledge that subjects may be involved within the period of support, but definite plans would not normally be set forth in the application or proposal. These include activities such as institutional type grants when selection of specific projects is the institution's responsibility; research training grants in which the activities involving subjects remain to be selected; and projects in which human subjects' involvement will depend upon completion of instruments, prior animal studies, or purification of compounds. These applications need not be reviewed by an IRB before an award may be made. However, except for research exempted or waived under Sec. 101 (b) or (i), no human subjects may be involved in any project supported by these awards until the project has been reviewed and approved by the IRB, as provided in this policy, and certification submitted to the department or agency.

Sec. 119 Research undertaken without the intention of involving human subjects.

In the event research is undertaken without the intention of involving human subjects, but it is later proposed to involve human subjects in the research, the research shall first be reviewed and approved by an IRB, as provided in this policy, a certification submitted to the department or agency, and final

approval given to the proposed change by the department or agency.

Sec. 120 Evaluation and disposition of applications and proposals for research to be conducted or supported by a Federal Department or Agency.

(a) The department or agency head will evaluate all applications and proposals involving human subjects submitted to the department or agency through such officers and employees of the department or agency and such experts and consultants as the department or agency head determines to be appropriate. This evaluation will take into consideration the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained.

(b) On the basis of this evaluation, the department or agency head may approve or disapprove the application or proposal, or enter into negotiations to develop an approvable one.

Sec. 121 Section reserved.

Sec. 122 Use of Federal funds.

Federal funds administered by a department or agency may not be expended for research involving human subjects unless the requirements of this policy have been satisfied.

Sec. 123 Early termination of research support; Evaluation of applications and proposals.

(a) The department or agency head may require that department or agency support for any project be terminated or suspended in the manner prescribed in applicable program requirements, when the department or agency head finds an institution has materially failed to comply with the terms of this policy.

(b) In making decisions about supporting or approving applications or proposals covered by this policy the department or agency head may take into account, in addition to all other eligibility requirements and program criteria, factors such as whether the applicant has been subject to a termination or suspension under paragraph (a) of this section and whether the applicant or the person who would direct or has directed the scientific and technical aspects of an activity has in the judgment of the department or agency head materially failed to discharge responsibility for the protection of the rights and welfare of human subjects (whether or not the research was subject to federal regulation).

Sec. 124 Conditions.

With respect to any research project or any class of research projects the department or agency head may impose additional conditions prior to or at the time of approval when in the judgment of the department or agency head additional conditions are necessary for the protection of human subjects.

Concurrences of Departments and Agencies Including Proposed Departures From the Model Policy

No Departures

Agency for International Development (AID)

Consumer Product Safety Commission (CPSC)

Department of Agriculture (USDA)

Department of Commerce (DOC)

Department of Defense (DOD)

Department of Energy (DOE)

Department of Housing and Urban Development (HUD)

Department of Justice (DOJ)

Department of Transportation (DOT)

Environmental Protection Agency (EPA)

National Aeronautics and Space Administration (NASA)

National Science Foundation (NSF)

Comment

Central Intelligence Agency (CIA)

The Central Intelligence Agency (CIA) is required by Executive Order 12333 to conform to the guidelines issued by the Department of Health and Human Services (HHS). Currently, the CIA follows the HHS regulations codified in 45 CFR Part 46. If, with respect to the CIA, HHS incorporates the Model Policy, the CIA will follow the model policy. The CIA fully concurs with the principles established in the Model Policy.

Proposed Departures

Department of Education (ED)

A departure for ED only that pertains only to research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior, conducted under a program subject to the General Education Provisions Act: *Revise* the exception to the Model Policy stated in Section 101(b)(3)(ii) to read as follows: "The research is conducted under a program subject to the protections of the General Education Provisions Act (GEPA), including GEPA Sections 400A (20 U.S.C. 1221–3), 438 (20 U.S.C. 1232g), and 439 (20 U.S.C. 1232h)."

Department of Health and Human Services (HHS).

1. Section 101(b)(6) of the HHS regulations (which becomes Section 101(b)(5) of the Model Policy) now has a qualifier found at 45 CFR 46.101(i): "(i) If, following review of proposed research activities that are exempt from these regulations under paragraph (b)(6), [of the HHS regulations] the Secretary determines that a research or demonstration project presents a danger to the physical, mental, or emotional well-being of a participant or subject of the research or demonstration project, then federal funds may not be expended for such a project without the written informed consent of each participant or subject."

HHS intends to retain this qualifier to exemption 6 in future regulations.

2. Section 103(g)—The Model Policy requires that institutions holding an approved assurance which covers a proposed research projects submit certification of IRB review and approval *along with* an application for funding. Current HHS regulations permit institutions to submit such certification along with the application *or* within 60 days of application for funding [45 CFR 46.103(f)]. At the time HHS publishes proposed rules and technical amendments designed to implement the Model Policy, HHS will request comment on whether or not the "60-day grace period" should be reduced or eliminated.

Food and Drug Administration (FDA)

1. Section 101(h)—The section of the Model Policy addresses research that takes place in foreign countries. FDA must diverge from the Model Policy with regard to those clinical investigations that take place in a foreign country and are conducted under a research permit granted by FDA. Such investigations must be carried out in accordance with the Federal Food, Drug, and Cosmetic Act (FD&C Act), which establishes certain requirements for the conduct of such investigations [see, e.g., 21 U.S.C. 355(i), 357(d)(3), and 360j(g)]. For these investigations, FDA does not have the authority to accept the procedures followed in a foreign country in lieu of the procedures required by the FD&C Act.

2. Section 116(d)—This section of the Model Policy permits altering or waiving of the informed consent requirements. FDA must depart from this provision of the Model Policy (See 21 CFR 50.20). The FD&C Act requires that informed

consent be obtained from all subjects of clinical investigations except in very limited circumstances [see e.g., 21 U.S.C. 355(i), 357(d)(3), and 360j(g)(3)(D)], which establish requirements for the conduct of clinical investigations for drugs, antibiotic drugs, and medical devises, respectively. FDA does not have authority under the FD&C Act to waive this requirement.

Veterans Administration (VA)

VA will continue intramural research and development practices of not permitting exempted research [Section 101(2)(b)] or expedited review [Section 110], not permitting waiver of informed consent [Section 116(c)] or "short form" written consent [Section 117(b)(2)], and not requiring written institutional assurances from VA medical centers [Section 103(a)]. Further, regarding cooperative research efforts under Section 114, VA requires that each VA medical center which participates in a cooperative or multi-hospital project must obtain the approval of its own Human Studies Subcommittee for such research.

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Part VI

Department of Housing and Urban Development

Office of the Assistant Secretary for Community Planning and Development

24 CFR Part 511

Rental Rehabilitation Program; Revised Minimum Allocation Amounts; Final Rule

Formula Allocations for the Rental Rehabilitation Program for Fiscal Year 1986 and Deadlines for Submission of Program Descriptions; Notice

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Community Planning and Development

24 CFR Part 511

[Docket No. R-86-1290; FR-2250]

Rental Rehabilitation Program: Revised Minimum Allocation Amounts

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Final rule.

SUMMARY: The current regulations for the Rental Rehabilitation Program impose a $50,000 minimum allocation amount for any city, urban county, or consortium otherwise eligible for a formula allocation under the program. The Department is concerned that the application of this minimum allocation amount to a city, urban county, or consortium that has a developed and operating local rental rehabilitation program would have a disruptive effect on the administration of the Rental Rehabilitation Program. To remedy this problem, the Department is revising the Rental Rehabilitation Program regulations to allow a city, urban county, or consortium that received a formula allocation in the preceding fiscal year and that has a formula allocation in the current fiscal year that is less than $50,000 to elect to receive its formula allocation.

EFFECTIVE DATE: July 21, 1986.

FOR FURTHER INFORMATION CONTACT: Mary Kolesar, Acting Director, Rental Rehabilitation Division, Office of Urban Rehabilitation, Room 7164, Department of Housing and Urban Development, 451 Seventh Street, S.W., Washington, D.C. 20410-7000, telephone (202) 755-5970. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION:

Background

Section 17 of the United States Housing Act of 1937 (the 1937 Act), 42 U.S.C. 1437o, established the Rental Rehabilitation Program. This Program provides grants to States and units of general local government to help support the rehabilitation of privately owned real property to be used for primarily residential rental purposes. The program is designed to increase the supply of standard housing units affordable to lower income families. This objective is achieved by: (1) Providing Rental Rehabilitation grant amounts to assist in the rehabilitation of existing units, and (2) authorizing the use of rental housing assistance, provided under section 8 of the 1937 Act, to lower income families to help them afford the rent for units in projects assisted with program funds, or to find alternative housing.

Section 511.31 establishes a $50,000 minimum for direct formula allocations of Rental Rehabilitation funds, except for States. A city or urban county that has a formula allocation below $50,000 (and is not part of a consortium described in § 511.65), may participate in the Program only through the State Program under Subpart F of Part 511. Such participation is dependent on meeting the criteria developed by each State for its particular program.

Reductions in program funding, as in fiscal year 1986, may cause many cities, urban counties, and consortia that have previously received formula allocations of $50,000 or more and have developed rental rehabilitation programs, to fail to meet the $50,000 minimum. In fiscal year 1986, these grantees would have to compete for funding through the applicable State Program, and would have to terminate their programs if they were not funded under the State Program.

The original purpose of the $50,000 minimum was to ensure that reasonable economies of scale existed with respect to the development and administration of local rental rehabilitation programs. These programs can be a time-consuming and costly undertaking and are frequently paid for by Community Development Block Grant funds under 24 CFR 570.202(b)(10). However, once programs have been developed and are operating, local administrative costs are lower and there is less need for such economies of scale. Therefore, to minimize the disruption of city, urban county, and consortium rental rehabilitation programs already developed in reliance on direct formula allocations, the Department is revising § 511.31 to allow a city, urban county, or consortium to elect to receive a formula allocation below $50,000 if the city, urban county, or consortium received a formula allocation in the preceding fiscal year. (Such an entity could also choose not to receive its formula allocation, which would then be added to the State's allocation. Then, the city, urban county, or jurisdictions making up the consortium, could participate in the State Program under the terms established by the State in question.

A city, urban county, or consortium that elects to receive a formula allocation below $50,000 must provide HUD written notification of its decision to receive the allocation. Such a city, urban county, or consortium has 30 days from the date of notification of the formula allocation in which to notify HUD of its decision. If it elects to receive the allocation, it has 45 days from the same date to submit its program description. For fiscal year 1986, the Department has provided notification of the formula allocations by publication, elsewhere in today's issue of the **Federal Register**, of its Notice of Formula Allocations for the Rental Rehabilitation Program for Fiscal Year 1986 and and Deadlines for Submission of Program Descriptions.

Other Information

A Finding of No Significant Impact with respect to the environment has been made in accordance with HUD regulations in 24 CFR Part 50, which implements section 102(2)(C) of the National Environmental Policy Act of 1969, 42 U.S.C. 4332. The Finding of No Significant Impact is available for public inspection during regular business hours in the Office of the General Counsel, Rules Docket Clerk, at the above address.

This rule does not constitute a "major rule" as that term is defined in Section 1(b) of the Executive Order on Federal Regulations issued by the President on February 17, 1981. Analysis of the rule indicates that it would not: (1) Have an annual effect on the economy of $100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or (3) have a significant adverse effect on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In accordance with the provisions of 5 U.S.C. 605(b), the Undersigned hereby certifies that this rule does not have a significant economic impact on a substantial number of small entities, because statutorily eligible grantees and State recipients are relatively larger cities, urban counties or States and the rental rehabilitation grant amounts to be made available to any grantee are relatively small in relation to other sources of Federal funding for State and local government and in relation to private investment in rental housing.

The subject matter of this rulemaking action relates to grants and is therefore exempt from the notice and public comment requirements of section 553 of the Administrative Procedure Act. As a matter of policy, the Department submits many rulemaking actions

containing such subject matter to public comment either before or after effectiveness of the action, notwithstanding the statutory exemption.

The Secretary has determined that notice and prior public procedure are impracticable and contrary to the public interest and that good cause exists for making this rule effective as soon after publication as possible because publication of this rule for earliest practicable effect is needed to prevent potential disruptions in the rental rehabilitation programs of those cities and urban counties that would otherwise be unable to receive a formula allocation in fiscal year 1986.

This rule was not listed in the Department's Semiannual Agenda of Regulations published on April 21, 1986, (51 FR 14036) under Executive Order 12291 and the Regulatory Flexibility Act.

The information collection requirements contained in § 511.31 of this rule have been submitted to the Office of Management and Budget for review under the provisions of the Paperwork Reduction Act of 1980. No person may be subjected to a penalty for failure to comply with these requirements until they have been approved and assigned an OMB control number. The OMB control number, when assigned, will be announced by separate notice in the **Federal Register.**

The Catalog of Federal Domestic Assistance program number is 14.230.

List of Subjects in 24 CFR Part 511

Administrative practice and procedure, Grant programs—Housing and community development, Low and moderate income housing, Rental rehabilitation grants, Reporting and recordkeeping requirements.

Accordingly, the Department amends 24 CFR 511 as follows:

PART 511—RENTAL REHABILITATION GRANT PROGRAM

1. The citation of authority for Part 511 continues to read as follows:

Authority: Sec. 17, U.S. Housing Act of 1937 (42 U.S.C. 1437o); sec. 7(d), Department of Housing and Urban Development Act (42 U.S.C. 3535(d)).

2. Section 511.31 is revised to read as follows:

§ 511.31 Minimum allocation amount.

(a) Except as provided in paragraph (b) of this section, the minimum allocation for any city, urban county, or consortium determined under the formula contained in § 511.30 for any fiscal year is $50,000. Cities, urban counties, and consortia with formula allocations of $50,000 or more will be deemed to meet this threshold, even if performance adjustments under § 511.32 reduce their grant amounts below $50,000. A formula allocation that is below $50,000 and is not received by a city, urban county, or consortium under paragraph (b) of this section will be added to the allocation for the State Program in which the city, urban county, or consortium is located. A city or urban county, or the jurisdictions in a consortium with a formula allocation below $50,000 that elects not to receive its allocation may participate in the State Program, as provided in Subpart F of this part.

(b) A city, urban county, or consortium that (1) received a formula allocation in the preceding fiscal year, and (2) has a formula allocation in the current fiscal year that is less than $50,000, may elect to receive its formula allocation by submitting written notification to HUD of its decision to do so within 30 days of the date of written notification of its proposed allocation for the fiscal year. If such a city, urban county, or consortium does not notify HUD within this period, HUD will regard the city, urban county, or consortium as having elected not to receive its formula allocation and will notify the appropriate State of its additional allocation. This election procedure does not affect the deadline for submitting program descriptions under § 511.20(a).

Dated: May 27, 1986.

DuBois L. Gilliam

Acting General Deputy Assistant Secretary for Community Planning and Development.

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DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Community Planning and Development

[Docket No. N-86-1612; FR-2242]

Notice of Formula Allocations for the Rental Rehabilitation Program for Fiscal Year 1986 and Deadlines for Submission of Program Descriptions

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This notice announces the allocations of Rental Rehabilitation Program funds for cities with populations of 50,000 or more, urban counties, consortia of units of general local government, and States for Fiscal Year 1986. It also sets the dates by which Program Descriptions must be submitted to HUD for these potential grantees to be considered for actual grants based upon these allocations.

FOR FURTHER INFORMATION CONTACT: Mary Kolesar, Acting Director, Rental Rehabilitation Division, Room 7162, Department of Housing and Urban Development, 451 7th Street, S.W., Washington, D.C. Telephone (202) 755-5970. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION:

Formula Allocations

The Rental Rehabilitation Program is authorized by section 17 of the United States Housing Act of 1937 (42 USC 1437o), hereafter referred to as section 17. The Program's interim regulations are published at 24 CFR Part 511 (49 FR 16936, April 20, 1984). Section 511.30 contains the formula for allocating Rental Rehabilitation Program funds. Cities having a population of 50,000 or more, urban counties, and consortia of units of general local government having a combined population of 50,000 or more and States are eligible to receive formula allocations. Since the amount of funding available for allocation in Fiscal Year 1986 is $71,775,000 instead of the $149,000,000 available in both Fiscal Year 1984 and Fiscal Year 1985, most cities, urban counties and consortia will receive less than half the amount they received in Fiscal Year 1985.

Appendix A to this notice contains the formula allocations for cities, urban counties and consortia that receive an allocation of $50,000 or more. Appendix B to this notice contains the minimum formula allocations for States. Appendix C to this notice contains formula allocations for localities that participated in the Rental Rehabilitation Program last year as formula grantees that may elect to participate as formula grantees in Fiscal Year 1986 (see discussion of this election in the following paragraphs).

The eligibility of cities with populations of 50,000 or more and urban counties for formula allocations is determined by whether they were so classified for purposes of the Community Development Block Grant Entitlement Program (24 CFR Part 570) for Federal Fiscal Year 1985. For city, urban county and consortium allocations, grant amounts have been rounded to the nearest thousand. The formula factors for allocating the Fiscal Year 1986 funds are the same as those used in Fiscal Years 1984 and 1985.

In the two prior years of the Rental Rehabilitation Program, a minimum allocation of $50,000 applied to all of these entities except States. For Fiscal Year 1986, because ony $71.775 million is available for allocation, many entities that received a formula allocation and participated in the Program last year would, under current regulatory provisions, be excluded as direct formula grantees in Fiscal Year 1986 because their formula allocations are less than the $50,000 minimum allocation (see Appendix C). In order to avoid disruption to city and urban county rental rehabilitation programs that have been developed in reliance on direct formula allocations, the Department is allowing a city, urban county, or consortium that received a formula allocation in Fiscal Year 1985 and has a formula allocation in Fiscal Year 1986 that is less than 50,000 to elect to receive its formula allocation or to participate in a State Program or, if the State elects not to administer the Program, in a HUD-administered Rental Rehabilitation Program for Small Cities. The Department is implementing this revision by final rule published elsewhere in today's issue of the **Federal Register.**

The rationale for the existing minimum allocation policy in 24 CFR 511.31 is that it is not cost-effective for a grantee to set up a Rental Rehabilitation Program for only the very small number of units that are being rehabilitated using a total grant of less than $50,000. However, this rationale does not apply to grantees that have already set up their programs and then receive less than $50,000 for a fiscal year because of a general reduction in funds available for the program.

The allocations indicated for States are the minimum amounts that they would receive. Amounts for those localities listed in Appendix C that do not elect to receive their formula allocations will also be allocated to the appropriate States.

Localities that would receive a formula amount of less than $50,000 must decide by July 3, 1986, whether to participate as a formula grantee (see discussion of deadlines for submission of program description below). If a locality elects to participate in a State Program (whether State-administered or HUD-administered), there is no assurance that it will receive funding since funding in such programs is under procedures set by the State grantee (or HUD if the State's program is HUD-administered).

Section 17(b) provides that the Secretary shall allocate rental rehabilitation funds based on a formula prescribed by the Secretary by regulation, taking into account various "objectively measurable conditions" and "excluding data relating to . . . areas eligible for assistance under Title V of the Housing Act of 1949." 24 CFR 511.30(d) currently provides that HUD will exclude data concerning rental units located in Title V-eligible areas from *all* formula allocations. Since the statutory prohibition on the use of rental rehabilitation funds in Title V-eligible areas pertains only to States' allocations (see section 17(e)(1)), HUD has concluded that Title V-area data should be excluded only from the calculation of formula allocations for States' and consortia, but not from urban counties' allocations. (There are no cities that contain Title V-eligible areas.) Retention of the existing Title V-area data exclusion for urban counties tends to understate urban county allocations and adversely affects achievement of the purposes of the Rental Rehabilitation Program in urban counties, and it is therefore waived in Fiscal Year 1986. However, the Department emphasizes that States' allocation funds, even if they result from an urban county not qualifying for a minimum allocation under § 511.31 or from a reallocation under § 511.33(b), may not be used in a Title V-eligible area, no matter where located.

Section 511.50 of the interim rule authorizes a State that elects to administer a Rental Rehabilitation Program to carry out eligible activities (1) in cities having populations of less than 50,000, and (2) in cities and urban counties whose allocations are below a minimum specified amount. Section 103(e)(1) of the Housing and Community Development Technical Amendments Act of 1984 (Pub. L. 98-479), amended the range of section 17(e)(1) of the United States Housing Act of 1937 by

eliminating reference to "cities with populations of less than fifty thousand" and substituting "units of general local government and areas of the State that do not receive allocations under subsection (b)."

The Assistant Secretary for Community Planning and Development has determined that this legislatively mandated change must be implemented for all Fiscal Years 1984, 1985 and 1986. This change was designed to permit Rental Rehabilitation activities to be carried out in all areas that contributed demography in determining the States' allocations, including urban counties. Language in § 511.50 that reflects the previous statute and that is inconsistent with the 1984 amendment is inapplicable by operation of law. Areas eligible for assistance under Title V of the Housing Act of 1949, of course, do not contribute demography to States' allocations and are specifically barred by section 17(e)(1) from participating in the program through a States' allocation, whether administered by the State or by HUD. The Department notes that jurisdictions that are the subject of a published allocation of $50,000, or more, and that decline that allocation, are also barred from participating in their States' program. Such declined funds are available for reallocation pursuant to § 511.33 (c) and (d).

Concerning the 1984 legislative amendment that the Secretary assure that an equitable share of funds be used to provide units for families with children, particularly large families requiring three or more bedroom units, the Department has determined for Fiscal Year 1986 that the three or more bedroom priority can be satisfied if at least 15 percent of the Rental Rehabilitation Program grant amounts expended nationwide are expended for rehabilitation of units of three or more bedrooms. In addition, the existing requirement in § 511.10(k) that grantees use at least 70 percent of their grant funds to provide two or more bedroom units, unless otherwise approved by HUD under the criteria in that section, remains in effect. If Fiscal Year 1987 funds are made available, each grantee's performance in achieving a high percentage of rehabilitation of three-bedroom units among all units rehabilitated will also be publicly rated through the "performance adjustment system" (see 24 CFR 511.32). As part of this system, grantees will be financially rewarded or penalized based in part on the extent to which they rehabilitate three-bedroom units, as well as two-bedroom units.

The Department reserves the right to establish a mandatory standard for each grantee for achievement of three-bedroom and larger units should the data (which will be continually available) indicate any substantial prospect that the Secretary will not achieve the mandated minimum within any 2-year period.

Deadline for Submitting Program Descriptions

Section 511.20(a) of the Program regulations states that cities, urban counties and consortia eligible to receive a grant based on a formula allocation must submit a Program Description to the appropriate HUD Field Office within 45 days of written notification of their Rental Rehabilitation fund allocation, and that States have 75 days from the date of written notification of their allocations to submit their Program Descriptions. Because HUD is publishing allocations this year, HUD regards the date of written notification to all grantees to be the date of this notice. However, since those entities listed in Appendix C, that would receive less than $50,000 have the option this year of applying directly to HUD or participating in a State Program, they must notify the appropriate HUD Field Office of their decision within 30 days of publication of this notice, to allow HUD more time to advise the affected States of any additional moneys that they will be allocated. However, if entities listed in Appendix C decide to participate as formula grantees, they still must submit a Program Description to the appropriate HUD Field Office within 45 days of written notification of their allocation. States that elect to participate in the Rental Rehabilitation Program must submit a Program Description to the appropriate HUD Field Office within 75 days of written notification of their original allocation, and HUD will endeavor to notify States as soon as possible of any additional allocation amounts resulting from the elections of entities listed in Appendix C not to participate as direct grantees in Fiscal Year 1986. In addition, HUD will administer the allocation for any State that does not notify the responsible HUD Field Office of its election to administer the Rental Rehabilitation Program within 30 days of written notification of its initial allocation.

Thus, all cities, urban counties and consortia receiving a formula allocation must deliver their Program Descriptions to the appropriate HUD Field Office or have them postmarked no later than July 18, 1986 to be considered for a grant. If a formula-eligible unit of general local government that would receive less than a $50,000 formula allocation chooses to participate as a formula grantee, it must notify HUD in writing of its decision as soon as possible, but no later than July 3, 1986 to facilitate HUD's notification to the affected State of the additional allocation. If a State elects to administer the Rental Rehabilitation Program in Fiscal Year 1986, it must notify HUD in writing of its intent to participate in the program by July 3, 1986 and must deliver its Program Description or have it postmarked by August 9, 1986 to be considered for a grant.

If a State chooses not to participate in the Rental Rehabilitation Program, eligible units of general local government located in the State that wish to participate in the HUD-Administered State Program must submit a Program Description to the responsible HUD Field Office within 45 days of the date stated in a written notification from HUD to such potential grantees of fund availability under the program for the fiscal year. These notifications will be directly issued by HUD Field Offices when it is known which States, if any, are not participating in Fiscal Year 1986.

Particularly close attention must be paid to these deadlines in Fiscal Year 1986 since under current law all unobligated Rental Rehabilitation budget authority lapses at close of business on September 30, 1986.

Section 8 Vouchers in Support of the Rental Rehabilitation Program

When Field Offices approve Program Descriptions for formula grantees, or as soon as possible thereafter, they should also reserve the appropriate amount of Section 8 funds in support of the locality's Rental Rehabilitation Program. If they have not already been received, the Section 8 funds will be assigned to Field Offices soon. Up to one Section 8 Housing Voucher will be provided for each $5,000 of rehabilitation grant funds allocated to a grantee.

If there are city/urban county formula grantees that had Rental Rehabilitation Program grant funds deobligated for poor performance earlier this fiscal year, adjustments should be made in the Section 8 funds allocated to those grantees for this fiscal year. Thus, if a grantee had $50,000 taken away for poor performance, that grantee should receive approximately 10 fewer Section 8 Vouchers this fiscal year. On the other hand, the grantee that received a $50,000 reallocation of additional Rental Rehabilitation grant funds for good performance, should receive, if possible, 10 additional Vouchers this fiscal year

to compensate for its not receiving any additional Vouchers for previously reallocated rehabilitation grant funds. Further instructions will be sent to Field Offices concerning adjustments that should be made for reallocations of Rental Rehabilitation grant funds, but Field Offices need to be aware that these adjustments are to be made.

If a locality that would receive less than a $50,000 formula amount of Rental Rehabilitation grant funds elects not to participate as a formula grantee, the Section 8 funds allocated for that locality would be added to the State balance amount along with the Rental Rehabilitation grant funds, as described above in this notice.

Other Matters

A Finding of No Significant Impact with respect to the environment has been made in accordance with HUD regulations in 24 CFR Part 50, which implement section 102(2)(C) of the National Environmental Policy Act of 1969, 42 U.S.C. 4332. The Finding of No Significant Impact is available for public inspection and copying during regular business hours in the Office of the Rules Docket Clerk, Room 10276, 451 Seventh Street, SW., Washington, DC., 20410–0500.

The Catalog of Federal Domestic Assistance program number is 14.230 Rental Housing Rehabilitation.

The collection of information requirements contained in this notice have been approved by the Office of Management and Budget (OMB) under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3520) and have been assigned OMB Control No. 2506–0078.

Authority: Sec. 17, United States Housing Act of 1937, 42 U.S.C. 1437o; Section 7(d). Department of Housing and Urban Development Act, 42 U.S.C. 3535(d)

Dated: May 27, 1986.

DuBois L. Gilliam,

Acting General Deputy Assistant Secretary for Community Planning and Development.

BILLING CODE 4210-29-M

RENTAL REHABILITATION PROGRAM
FORMULA ALLOCATIONS
FOR
CITIES, URBAN COUNTIES AND CONSORTIA

FY1986

APPENDIX A

STATE LOCALITY	TYPE OF LOCALITY*	$ IN THOUSANDS
ALABAMA		
BIRMINGHAM	51	177
MOBILE	51	81
MONTGOMERY	51	74
JEFFERSON COUNTY	66	63
ALASKA		
ARIZONA		
PHOENIX	51	259
TUCSON	51	150
ARKANSAS		
LITTLE ROCK	51	64
CALIFORNIA		
ANAHEIM	51	83
BERKELEY	51	102
FRESNO	51	108
GLENDALE	52	82
HUNTINGTON BEACH	52	50
INGLEWOOD	52	60
LONG BEACH	51	242
LOS ANGELES	51	2061
OAKLAND	51	261
PASADENA	51	72
RIVERSIDE	51	62
SACRAMENTO	51	140
SAN BERNADINO	51	54
SAN DIEGO	51	427
SAN FRANCISCO	51	608
SAN JOSE	51	180
SANTA ANA	51	86
SANTA BARBARA	51	52
SANTA MONICA	52	71
STOCKTON	51	80
ALAMEDA COUNTY	66	57
CONTRA COSTA	66	77
FRESNO COUNTY	66	81
KERN COUNTY	66	86
LOS ANGELES COUNTY	66	727
MARIN COUNTY	66	72
ORANGE COUNTY	66	143
RIVERSIDE COUNTY	66	120
SACRAMENTO COUNTY	66	143
SAN BERNARDINO COUNTY	66	160
SAN DIEGO COUNTY	66	146
SAN JOAQUIN COUNTY	66	54
SAN MATEO COUNTY	66	81
SANTA CLARA COUNTY	66	73
SONOMA COUNTY	66	66
COLORADO		
COLORADO SPRINGS	51	79
DENVER	51	299
CONNECTICUT		
BRIDGEPORT	51	122
HARTFORD	51	145
NEW HAVEN	51	128
WATERBURY	51	66
DELAWARE		
NEW CASTLE COUNTY	66	67
DISTRICT OF COLUMBIA		
WASHINGTON	51	443
FLORIDA		
FT LAUDERDALE	51	76
GAINESVILLE	51	52
HIALEAH	51	66
JACKSONVILLE	51	208
MIAMI	51	332
MIAMI BEACH	51	158
ORLANDO	51	66
ST PETERSBURG	51	108
TALLAHASSEE	51	62
TAMPA	51	129
BROWARD COUNTY	66	132
DADE COUNTY	66	302
HILLSBOROUGH COUNTY	66	84

STATE LOCALITY	TYPE OF LOCALITY*	$ IN THOUSANDS
FLORIDA		
ORANGE COUNTY	66	90
PALM BEACH COUNTY	66	91
PINELLAS COUNTY	66	65
POLK COUNTY	66	56
GEORGIA		
ATLANTA	51	311
COLUMBUS	51	79
MACON	51	71
SAVANNAH	51	87
DE KALB COUNTY	66	106
FULTON COUNTY	66	62
HAWAII		
HONOLULU	51	270
IDAHO		
ILLINOIS		
CHICAGO	51	2562
PEORIA	51	53
ROCKFORD	51	51
COOK COUNTY	66	239
DU PAGE COUNTY	66	72
MADISON COUNTY	66	66
ST CLAIR COUNTY	66	57
INDIANA		
EVANSVILLE	51	59
FORT WAYNE	51	64
GARY	51	69
INDIANAPOLIS	51	270
IOWA		
DES MOINES	51	80
KANSAS		
KANSAS CITY	51	61
WICHITA	51	101
KENTUCKY		
LEXINGTON-FAYETTE	51	97
LOUISVILLE	51	189
JEFFERSON COUNTY	66	66
LOUISIANA		
BATON ROUGE	51	122
NEW ORLEANS	51	503
SHREVEPORT	51	84
JEFFERSON PARISH	66	97
MAINE		
PORTLAND	51	59
MARYLAND		
BALTIMORE	51	620
BALTIMORE COUNTY	66	126
MONTGOMERY COUNTY	66	110
PRINCE GEORGES COUNTY	66	156
MASSACHUSETTS		
BOSTON	51	573
BROCKTON	51	56
CAMBRIDGE	51	87
FALL RIVER	51	73
LAWRENCE	51	59
LOWELL	51	61
LYNN	51	60
NEW BEDFORD	51	79
SOMERVILLE	52	64
SPRINGFIELD	51	108
WORCESTER	51	104
MICHIGAN		
ANN ARBOR	51	64
DETROIT	51	880
FLINT	51	74

STATE LOCALITY	TYPE OF LOCALITY*	$ IN THOUSANDS
MICHIGAN		
GRAND RAPIDS	51	89
KALAMAZOO	51	55
LANSING	51	63
OAKLAND COUNTY	66	67
WAYNE COUNTY	66	80
MINNESOTA		
DULUTH	51	52
MINNEAPOLIS	51	255
ST PAUL	51	124
HENNEPIN COUNTY	66	78
MISSISSIPPI		
JACKSON	51	84
MISSOURI		
KANSAS CITY	51	219
ST LOUIS	51	382
SPRINGFIELD	51	60
ST LOUIS COUNTY	66	130
MONTANA		
NEBRASKA		
LINCOLN	51	66
OMAHA	51	130
NEVADA		
LAS VEGAS	51	69
RENO	51	53
CLARK COUNTY	66	94
NEW HAMPSHIRE		
MANCHESTER	51	58
NEW JERSEY		
CAMDEN	51	69
EAST ORANGE	52	67
ELIZABETH	51	77
JERSEY CITY	51	219
NEWARK	51	391
PASSAIC	52	62
PATERSON	51	137
TRENTON	51	72
UNION CITY	52	63
BERGEN COUNTY	66	196
BURLINGTON COUNTY	66	52
CAMDEN COUNTY	66	57
ESSEX COUNTY	66	94
HUDSON COUNTY	66	167
MIDDLESEX COUNTY	66	50
MONMOUTH COUNTY	66	87
UNION COUNTY	66	79
NEW MEXICO		
ALBUQUERQUE	51	123
NEW YORK		
ALBANY	51	94
BUFFALO	51	361
MOUNT VERNON	52	57
NEW YORK	51	7523
ROCHESTER	51	194
SCHENECTADY	51	52
SYRACUSE	51	147
UTICA	51	82
YONKERS	52	116
NASSAU COUNTY	66	204
ORANGE COUNTY	66	51
ROCKLAND COUNTY	66	51
SUFFOLK COUNTY	66	86
WESTCHESTER COUNTY	66	107
NORTH CAROLINA		
CHARLOTTE	51	125
DURHAM	51	66
GREENSBORO	51	59
RALEIGH	51	65
WINSTON SALEM	51	68

STATE LOCALITY	TYPE OF LOCALITY*	$ IN THOUSANDS
NORTH DAKOTA		
OHIO		
AKRON	51	116
CINCINNATI	51	347
CLEVELAND	51	491
COLUMBUS	51	330
DAYTON	51	138
TOLEDO	51	173
YOUNGSTOWN	51	66
CUYAHOGA COUNTY	66	110
HAMILTON COUNTY	66	77
MONTGOMERY COUNTY	66	53
OKLAHOMA		
OKLAHOMA CITY	51	155
TULSA	51	130
OREGON		
EUGENE	51	65
PORTLAND	51	250
MULTNOMAH COUNTY	66	58
WASHINGTON COUNTY	66	59
PENNSYLVANIA		
ALLENTOWN	51	55
ERIE	51	67
PHILADELPHIA	51	1129
PITTSBURGH	51	333
READING	51	59
SCRANTON	51	51
ALLEGHENY COUNTY	66	235
BUCKS COUNTY	66	59
CHESTER COUNTY	66	61
DELAWARE COUNTY	66	76
LANCASTER COUNTY	66	57
LUZERNE COUNTY	66	61
MONTGOMERY COUNTY	66	84
WASHINGTON COUNTY	66	63
WESTMORELAND COUNTY	66	62
RHODE ISLAND		
PROVIDENCE	51	166
SOUTH CAROLINA		
CHARLESTON	51	55
COLUMBIA	51	54
GREENVILLE COUNTY	66	53
SOUTH DAKOTA		
TENNESSEE		
CHATTANOOGA	51	87
KNOXVILLE	51	103
MEMPHIS	51	313
NASHVILLE-DAVIDSON	51	178
TEXAS		
AUSTIN	51	199
CORPUS CHRISTI	51	83
DALLAS	51	411
EL PASO	51	179
FORT WORTH	51	140
HOUSTON	51	660
LUBBOCK	51	66
SAN ANTONIO	51	318
WACO	51	55
HARRIS COUNTY	66	79
UTAH		
SALT LAKE CITY	51	107
VERMONT		
VIRGINIA		
NEWPORT NEWS	51	61
NORFOLK	51	156
RICHMOND	51	150
ROANOKE	51	51
VIRGINIA BEACH	51	59

STATE LOCALITY	TYPE OF LOCALITY*	$ IN THOUSANDS
VIRGINIA		
ARLINGTON COUNTY	66	69
FAIRFAX COUNTY	66	96
WASHINGTON		
SEATTLE	51	306
SPOKANE	51	108
TACOMA	51	88
KING COUNTY	66	118
PIERCE COUNTY	66	77
WEST VIRGINIA		
WISCONSIN		
MADISON	51	109
MILWAUKEE	51	368
WYOMING		
PUERTO RICO		
MAYAGUEZ MUNICIPIO	51	61
PONCE MUNICIPIO	51	81
SAN JUAN MUNICIPIO	51	317

*51 = Central City
52 = Suburban City
66 = Urban County

APPENDIX B

RENTAL REHABILITATION PROGRAM ALLOCATIONS BY STATES
FISCAL YEAR 1986

	CITY/COUNTY AMOUNT	MINIMUM STATE AMOUNT	CITY/COUNTY/STATE TOTAL AMOUNT
ALABAMA	$ 482	$ 449	$ 931
ALASKA	47	29	76
ARIZONA	552	170	722
ARKANSAS	119	363	482
CALIFORNIA	7,897	1,566	9,463
COLORADO	562	275	837
CONNECTICUT	542	437	979
DELAWARE	116	20	136
DISTRICT OF COLUMBIA	443	0	443
FLORIDA	2,300	715	3,015
GEORGIA	808	648	1,456
HAWAII	270	39	309
IDAHO	35	139	174
ILLINOIS	3,401	794	4,195
INDIANA	667	513	1,180
IOWA	246	338	584
KANSAS	241	280	521
KENTUCKY	342	410	752
LOUISIANA	925	354	1,279
MAINE	59	241	300
MARYLAND	1,057	179	1,236
MASSACHUSETTS	1,452	931	2,383
MICHIGAN	1,554	781	2,335
MINNESOTA	537	328	865
MISSISSIPPI	84	403	487
MISSOURI	861	388	1,249
MONTANA	29	154	183
NEBRASKA	196	127	323
NEVADA	216	40	256
NEW HAMPSHIRE	85	138	223
NEW JERSEY	2,187	493	2,680
NEW MEXICO	123	184	307
NEW YORK	9,526	931	10,457
NORTH CAROLINA	472	653	1,125
NORTH DAKOTA	29	81	110
OHIO	2,204	931	3,135
OKLAHOMA	345	369	714
OREGON	514	279	793
PENNSYLVANIA	2,739	899	3,638
RHODE ISLAND	214	217	431
SOUTH CAROLINA	226	405	631
SOUTH DAKOTA	30	100	130
TENNESSEE	681	403	1,084
TEXAS	2,620	1,267	3,887
UTAH	222	97	319
VERMONT	0	110	110
VIRGINIA	830	391	1,221
WASHINGTON	773	435	1,208
WEST VIRGINIA	69	237	306
WISCONSIN	578	501	1,079
WYOMING	0	83	83
PUERTO RICO	651	302	953
U.S. TOTALS	$51,158	$20,617	$71,775

APPENDIX C

RENTAL REHABILITATION OPTIONAL GRANTEES FY1986

STATE	LOCALITY	$ IN THOUSANDS
ALABAMA	HUNTSVILLE	41
	TUSCALOOSA	46
	TOTAL	87
ALASKA	ANCHORAGE	47
	TOTAL	47
ARIZONA	GLENDALE	26
	MESA	38
	MARICOPA COUNTY	48
	PIMA COUNTY	31
	TOTAL	143
ARKANSAS	FORT SMITH	29
	PINE BLUFF	26
	TOTAL	55
CALIFORNIA	ALAMEDA	31
	ALHAMBRA	34
	BAKERSFIELD	41
	CHULA VISTA	28
	COMPTON	36
	CONCORD	25
	COSTA MESA	39
	EL CAJON	37
	EL MONTE	44
	ESCONDIDO CITY	27
	FREMONT	25
	GARDEN GROVE	35
	HAYWARD	31
	MODESTO	36
	OCEANSIDE	32
	ONTARIO	26
	ORANGE	26
	OXNARD	39
	POMONA	37
	REDONDO BEACH	27
	RICHMOND	32
	SALINAS	33
	SAN MATEO	29
	SANTA CLARA	30
	SANTA ROSA	33
	SOUTH GATE	31
	SUNNYVALE	31
	VALLEJO	25
	VENTURA	30
	TOTAL	930
COLORADO	AURORA	34
	BOULDER	45
	FORT COLLINS	34
	GREELEY	29
	PUEBLO	42
	TOTAL	184
CONNECTICUT	NEW BRITAIN	42
	STAMFORD	39
	TOTAL	81
DELAWARE	WILMINGTON	49
	TOTAL	49
FLORIDA	CLEARWATER	30
	DAYTONA BEACH	40
	HOLLYWOOD	39
	PENSACOLA	27
	WEST PALM BEACH	40
	VOLUSIA COUNTY	47
	TOTAL	223
GEORGIA	ALBANY	46
	COBB COUNTY	46
	TOTAL	92
IDAHO	BOISE	35
	TOTAL	35
ILLINOIS	AURORA	25
	CHAMPAIGN	37
	DECATUR	37
	EAST ST LOUIS	49
	EVANSTON	36
	JOLIET	29
	SPRINGFIELD	44
	LAKE COUNTY	44
	TOTAL	301
INDIANA	BLOOMINGTON	38
	HAMMOND	33
	MUNCIE	42
	SOUTH BEND	39
	TERRE HAUTE	28
	LAKE COUNTY	25
	TOTAL	205
IOWA	CEDAR RAPIDS	32
	DAVENPORT	42
	IOWA CITY	33
	SIOUX CITY	32
	WATERLOO	27
	TOTAL	166
KANSAS	LAWRENCE	37
	TOPEKA	42
	TOTAL	79
LOUISIANA	ALEXANDRIA	29
	LAFAYETTE	31
	LAKE CHARLES	26
	MONROE	33
	TOTAL	119
MARYLAND	ANNE ARUNDEL COU	45
	TOTAL	45
MASSACHUSETTS	BROOKLINE	37
	PITTSFIELD	25
	QUINCY	38
	WALTHAM	28
	TOTAL	128

STATE	LOCALITY	$ IN THOUSANDS
MICHIGAN	BATTLE CREEK	29
	PONTIAC	37
	SAGINAW	44
	GENESEE COUNTY	42
	MACOMB COUNTY	30
	TOTAL	182
MINNESOTA	DAKOTA COUNTY	28
	TOTAL	28
MISSOURI	COLUMBIA	36
	ST JOSEPH	34
	TOTAL	70
MONTANA	BILLINGS	29
	TOTAL	29
NEW HAMPSHIRE	NASHUA	27
	TOTAL	27
NEW JERSEY	BAYONNE	37
	IRVINGTON	49
	GLOUCESTER COUNT	43
	MORRIS COUNTY	46
	OCEAN COUNTY	41
	SOMERSET COUNTY	32
	TOTAL	248
NEW YORK	BABYLON TOWN	35
	BINGHAMTON	47
	ISLIP TOWN	47
	NEW ROCHELLE	37
	NIAGARA FALLS	44
	TROY	45
	DUTCHESS COUNTY	38
	ERIE COUNTY	46
	MONROE COUNTY	49
	ONONDAGA COUNTY	33
	TOTAL	421
NORTH CAROLINA	ASHEVILLE	28
	FAYETTEVILLE	31
	HIGH POINT	30
	TOTAL	89
NORTH DAKOTA	FARGO	29
	TOTAL	29
OHIO	CANTON	48
	HAMILTON CITY	33
	LAKEWOOD	28
	LORAIN	25
	MANSFIELD	26
OHIO (CONT)	SPRINGFIELD	47
	FRANKLIN COUNTY	45
	STARK COUNTY	24
	SUMMIT COUNTY	27
	TOTAL	303
OKLAHOMA	LAWTON	30
	NORMAN	30
	TOTAL	60
OREGON	SALEM	41
	CLACKAMAS COUNTY	41
	TOTAL	82
PENNSYLVANIA	ALTOONA	26
	HARRISBURG	40
	LANCASTER	39
	UPPER DARBY	25
	WILKES-BARRE	30
	BEAVER COUNTY	49
	BERKS COUNTY	35
	YORK COUNTY	43
	TOTAL	287
RHODE ISLAND	PAWTUCKET	48
	TOTAL	48
SOUTH CAROLINA	GREENVILLE	36
	NORTH CHARLESTON	28
	TOTAL	64
SOUTH DAKOTA	SIOUX FALLS	30
	TOTAL	30
TEXAS	ABILENE	30
	AMARILLO	41
	BEAUMONT	46
	BROWNSVILLE	39
	GALVESTON	35
	LAREDO	42
	PASADENA	29
	SAN ANGELO	25
	TYLER	28
	WICHITA FALLS	32
	TARRANT COUNTY	43
	CONSORT KILLEEN-TEMPLE	40
	TOTAL	430
UTAH	OGDEN	31
	PROVO	38
	SALT LAKE COUNTY	46
	TOTAL	115
VIRGINIA	ALEXANDRIA	48
	CHESAPEAKE	27
	HAMPTON	37
	LYNCHBURG	27
	PORTSMOUTH	49
	TOTAL	188

STATE	LOCALITY	$ IN THOUSANDS
WASHINGTON	EVERETT	29
	SNOHOMISH COUNTY	47
	TOTAL	76
WEST VIRGINIA	CHARLESTON	30
	HUNTINGTON	39
	TOTAL	69
WISCONSIN	GREEN BAY	35
	RACINE	31
	MILWAUKEE COUNTY	35
	TOTAL	101
PUERTO RICO	AGUADILLA	27
	ARECIBO	30
	BAYAMAON MUNICIP	49
	CAGUAS MUNICIPIO	39
	CAROLINA MUNICIP	47
	TOTAL	192

[FR Doc. 86-12445 Filed 6-2-86; 8:45 am]
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federal register

Tuesday
June 3, 1986

Part VII

Department of Education

Educational Media Research, Production, Distribution, and Training; Proposed Funding Priority for Fiscal Year 1986; Notice

DEPARTMENT OF EDUCATION

Educational Media Research, Production, Distribution, and Training; Proposed Funding Priority for Fiscal Year 1986

AGENCY: Department of Education.

ACTION: Notice of Proposed Funding Priority for Fiscal Year 1986.

SUMMARY: The Secretary proposes an annual funding priority for the Educational Media, Research, Production, Distribution, and Training program. To ensure a continuing supply of Line 21 television decoders for the Nation's hearing-impaired population, the Secretary proposes to establish a single funding priority for fiscal year 1986 for a project to manufacture at least 33,000 additional Line 21 decoders. The Secretary would give an absolute preference to applications that meet the terms of the proposed priority.

DATE: Comments must be received on or before July 3, 1986.

ADDRESS: All written comments and suggestions should be sent to Dr. Malcolm J. Norwood, Division of Innovation and Development, Department of Education, 400 Maryland Ave., SW. (Room 4088, Switzer Building), Washington, DC 20202.

FOR FURTHER INFORMATION CONTACT: Dr. Malcolm J. Norwood, Telephone: (202) 732-1177.

SUPPLEMENTARY INFORMATION: The Educational Media, Research, Production, Distribution and Training program is designed to promote the educational advancement of handicapped persons by providing assistance for: (a) Conducting research on the use of educational media and technology for handicapped persons; (b) Producing and distributing educational media for the use of handicapped persons, their parents, their actual or potential employers, and other persons directly involved in work for the advancement of handicapped persons; and (c) training persons in the use of educational media for the instruction of handicapped persons.

In 1972 the Federal Government, through the former Office of Education, initiated the development of the closed-captioned Line 21 system to make television accessible to the Nation's hearing-impaired population. Closed-captioning is a system that uses Line 21 of the broadcasting signal for the benefit of viewers with hearing impairments to transmit captions (subtitles) which may be made visible only on television sets that are equipped with decoders.

Upon completion of the development of the system, the Department supported the creation of the National Captioning Institute to provide captioning services to the broadcasting industry and helped subsidize 100,000 large-scale integrated-circuit chips which made the manufacture of Line 21 decoders possible.

The system was implemented in March 1980 and has resulted in cooperative efforts between the public and private sectors to provide closed-captioned television to hearing-impaired Americans. All major networks are making closed-captioned programs available. Federal funding supports approximately 50% of current programming, the networks support approximately 30%, and corporate advertisers, foundations, and contributions account for the remaining 20%. Closed-captioning provides the only acceptable system that makes television access for deaf persons possible. Open captioning which would appear on all television sets is disturbing to the general viewing audience and, therefore, is not an acceptable alternative to the broadcasting industry and private sector supporters of captioning services.

The original stock of Line 21 decoders was depleted during 1985. The Congress, provided $1.5 million during fiscal year 1985 to assist in the underwriting of the manufacture of 50,000 more chips to ensure a continuing supply.

More recently the Senate Committee on Appropriations directed the Secretary to provide $1.0 million during fiscal year 1986 for the purpose of manufacturing additional Line 21 decoders to assure that these devices will be available to meet a continuing need.

Proposed Priority

In accordance with the Education Department General Administrative Regulations (EDGAR) at 34 CFR 75.105(c)(3), the Secretary proposes to give an absolute preference to applications submitted under the Educational Media, Research, Production, Distribution, and Training program in fiscal year 1986 that respond to the priority described below. An absolute preference is one which permits the Secreary to select only those applications that meet the described priority.

All applications submitted under the Educational Media, Research, Production, Distribution and Training program must address the priority for a project to manufacture at least 33,000 additional Line 21 decoders to ensure a continuing supply of these devices for the Nation's hearing-impaired population.

The selection of this proposed priority is based upon the Congressional appropriation report language indicating that $1.0 million should be spent under Pub. L. 98-619 to underwrite the production of 50,000 additional Line 21 decoders before the current supply is exhausted. The proposed priority provides for the production of at least 33,000 additional Line 21 decoders rather than 50,000. At this level, a subsidy of $30 per decoder would be provided, thereby reducing the retail price of decoders. The Department believes that pricing at a lower level is necessary in order to promote the sale of decoders.

This proposed priority will support a cooperative agreement with an organization which has the technical expertise and knowledge to assure that the hearing-impaired population will have a continuing supply of Line 21 decoders available.

The applicant shall submit a working plan for the subsequent production of at least 33,000 additional Line 21 decoder modules as part of the application. The plan shall provide for a fully assembled unit (i.e., large-scale-integrated (LSI) circuit chip set, circuit board, and adapter unit) with evidence of commitment from one or more manufacturers and retailers to assure production and sale of the units. The plan shall contain a timeline for testing and production and an estimated retail price for the assembled units to be marketed to hearing-impaired consumers. The plan shall also provide assurances that at least 33,000 Line 21 decoders will be produced for marketing to consumers at the estimate price. An applicant, however, could propose a project for more than 33,000 Line 21 decoders if provisions can be made for the production and marketing of that number of decoders at an acceptable price.

Intergovernmental Review

This program is subject to the requirements of Executive Order 12372 and the regulations in 34 CFR Part 79 (48 FR 29158; June 24, 1983). The objective of the Executive Order is to foster an intergovernmental partnership and a strengthened federalism by relying on State and local processes for State and local governmental coordination and review of proposed Federal financial assistance.

In accordance with the Order, this document is intended to provide early notification of the Department's specific plans and actions for this program.

Invitation To Comment

Interested persons are invited to submit comments and recommendations regarding the proposed priority. Written comments and recommendations may be sent to the address given at the beginning of this document. All comments received on or before the 30th day after publication of this document will be considered before the Secretary issues the final notice of priority. All comments submitted in response to this proposed priority will be available for public inspection, during and after the comment period, in room 4088, Mary E. Switzer Bldg., 330 C Street, SW., Washington, DC between the hours of 8:30 a.m. and 4:30 p.m. (local time), Monday through Friday of each week, except Federal holidays.

(20 U.S.C. 1451, 1452)

(Catalog of Federal Domestic Assistance No. 84.026, Educational Media Research, Production, Distribution, and training)

Dated: May 29, 1986.

William J. Bennett,

Secretarty of Education.

[FR Doc. 86-12454 Filed 6-2-86; 8:45 am]

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Federal Register

Tuesday
June 3, 1986

Part VIII

Department of Defense
General Services Administration
National Aeronautics and Space Administration

48 CFR Parts 1, 15, 30, 31, 52, and 53
Federal Acquisition Regulation (FAR); FAR System, Contracting by Negotiation, Cost Accounting Standards, Contract Cost Principles and Procedures, Solicitation Provisions, Contract Clauses, and Forms; Proposed Rule

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

48 CFR Parts 1, 15, 30, 31, 52, and 53

Federal Acquisition Regulation (FAR); FAR System, Contracting by Negotiation, Cost Accounting Standards, Contract Cost Principles and Procedures, Solicitation Provisions, Contract Clauses, and Forms; Proposed Rules

AGENCIES: Department of Defense (DoD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Proposed rule; notice of availability and requests for comments.

SUMMARY: The Civilian Agency Acquisition Council and the Defense Acquisition Regulatory Council are considering changes to FAR Part 30 which will incorporate into the FAR as regulations, the Cost Accounting Standards (CAS) and certain rules and regulations promulgated by the Cost Accounting Standards Board (CASB) under Pub. L. 91-379.

DATE: Comments should be submitted to the FAR Secretariat at the address shown below on or before August 4, 1986 to be considered in the formulation of a final rule.

ADDRESS: Interested parties may obtain copies of the proposed text from the FAR Secretariat and written comments should be submitted to:

General Services Administration, FAR Secretariat (VRS), 18th & F Streets NW, Room 4041, Washington, DC 20405

Please cite FAR Case 86-31 in all correspondence related to this issue.

FOR FURTHER INFORMATION CONTACT: Ms. Margaret A. Willis, FAR Secretariat, Telephone (202) 523-4755.

SUPPLEMENTARY INFORMATION:

A. Background

The proposed revisions to FAR Part 30 incorporating the CAS and CASB rules into the FAR as regulations require corollary changes to FAR Parts 1, 15, 31, 52, and 53. No changes to the substance of the Cost Accounting Standards or existing rules and regulations are being proposed at this time. However, it is anticipated that future revisions of the CAS as restated in Subpart 30.4 of this proposal will be processed as FAR revisions in accordance with normal procedures for revising the FAR.

The procedures for administering Facilities Capital Cost of Money under CAS 414 and previously included in DFARS 30.70 and 30.71, and FPR Subpart 1-3.13, have been rewritten with no material change in content and are relocated in FAR Subpart 30.5. Also, Form CASB-CMF, Facilities Capital Cost of Money Factors Computation, and Form CASB-DS-1, Disclosure Statement, are being changed to DOD forms with no change in format. Both forms will be illustrated in FAR Part 53. Finally, the clauses at FAR 52.215-30, Facilities Capital Cost of Money, and 52.215-31, Waiver of Facilities Capital Cost of Money, have been rewritten to facilitate their use.

It is recognized that proposed FAR 30.301 duplicates some definitions already contained in FAR 31.001. This will be adjusted in the final rule.

B. Regulatory Flexibility Act

The proposed revisions to FAR Parts 1, 15, 30, 31, 52, and 53 are not expected to have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601, et seq.) because the changes cover Cost Accounting Standards (CAS) and associated rules and regulations from which small business concerns are exempt.

C. Paperwork Reduction Act

The proposed revisions to FAR Parts 1, 15, 30, 31, 52, and 53 incorporate into the FAR as regulations the Cost Accounting Standards (CAS), and associated rules and regulations promulgated by the CAS Board under Pub. L. 91-379 and codified at 4 CFR Part 331. The rules do not change or otherwise affect the collection of information by Federal agencies from offerors, contractors, or members of the public because the rules previously existed as CAS Board Standards and Rules and Regulations. A request for a one-year extension of the recordkeeping and information requirements in Part 30 was submitted to the Office of Management and Budget on February 20, 1986.

List of Subjects in 48 CFR Parts 1, 15, 30, 31, 52, and 53

Government procurement.

Dated: May 29, 1986.

Lawrence J. Rizzi,

Director, Office of Federal Acquisition and Regulatory Policy.

[FR Doc. 86-12416 Filed 6-2-86; 8:45 am]

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Federal Register

Tuesday
June 3, 1986

Part IX

Department of Commerce

International Trade Administration

Oil Country Tubular Goods From Argentina; Final Determination of Sales at Not Less Than Fair Value; Notice

DEPARTMENT OF COMMERCE

International Trade Administration

[A-357-501]

Oil Country Tubular Goods From Argentina; Final Determination of Sales at Not Less Than Fair Value

AGENCY: International Trade Administration, Import Administration, Commerce.

ACTION: Notice.

SUMMARY: We have determined that oil country tubular goods from Argentina are not being, nor are likely to be, sold in the United States at less than fair value, and have notified the U.S. International Trade Commission (ITC) of our determination. We have also directed the U.S. Customs Service to discontinue the suspension of liquidation of all entries of oil country tubular goods (OCTG) from Argentina that are entered, or withdrawn from warehouse, for consumption, on or after January 27, 1986.

EFFECTIVE DATE: June 3, 1986.

FOR FURTHER INFORMATION CONTACT: Mary S. Clapp, Office of Investigations, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone: (202) 377-1769.

Final Determination

We have determined that oil country tubular goods (OCTG) from Argentina are not being, nor are likely to be, sold in the United States at less than fair value, as provided in section 735(a) of the Tariff Act of 1930, as amended (19 U.S.C. 1673d(a)) (the Act). We made fair value comparisons on all sales of the class or kind of merchandise to the United States by the respondent during the period of investigation. The weighted-average margin is 0.05 percent which is *de minimis*.

Case History

On July 22, 1985, we received a petition from the Lone Star Steel Company (Lone Star) and CF&I Steel Corporation (CF&I) on behalf of the OCTG industry. In compliance with the filing requirements of § 353.36 of the Commerce Regulations (19 CFR 353.36), the petition alleged that imports of OCTG from Argentina are being, or are likely to be, sold in the United States at less than fair value within the meaning of section 731 of the Act, and that these imports are materially injuring, or threatening material injury to, a United States industry. The petition also alleged that sales of the subject merchandise were being made at less than the cost of production.

After reviewing the petition, we determined that it contained sufficient grounds upon which to initiate an antidumping duty investigation. The petitioners, however, did not provide information sufficient to justify our initiating a cost of production investigation. We notified the ITC of our action and initiated such an investigation on August 12, 1985 (50 FR 33386). On September 11, 1985, the ITC determined that there is a reasonable indication that imports of OCTG from Argentina are materially injuring, or are threatening material injury to, a U.S. industry (10 FR 37066).

On September 3, we presented an antidumping duty questionnaire to Dalmine Siderca S.A.I.C. (Dalsid) the only known exporter of OCTG in Argentina. The respondent was requested to answer the questionnaire in 30 days. However, at the request of the company we granted an extension of time for the response submission, and on October 31, 1985, we received Dalsid's response to the questionnaire. After receipt of the response, the petitioners alleged that the reported sales were at prices below cost of production. We found that petitioners' allegation contained elements necessary for us to initiate a cost of production investigation, and did so on December 27, 1985.

On December 5, 1985, the petitioners requested that the Department postpone the preliminary determination until not later than January 21, 1986. The Department granted the request on December 16, 1985 (50 FR 51275). On December 26, 1985, the petitioners alleged that "critical circumstances" exist with respect to imports of OCTG from Argentina.

On January 27, 1986, we published a preliminary determination that OCTG from Argentina were being sold at less than fair value in the United States and that critical circumstances did not exist (51 FR 3387).

After the preliminary determination, the respondent in this investigation requested a postponement of the final determination date. We granted the request and postponed our final determination until May 21, 1986 on March 3, 1986 (51 FR 7977).

On February 14 through 17, 1986, we verified the information provided by the respondent at its facilities outside of Buenos Aires, Argentina on April 4, 1986, Houston, Texas. On April 21, 1986, we held a hearing to provide all interested parties with an opportunity to comment on the preliminary determination.

Products Under Investigation

The products covered by this investigation are oil country tubular goods (OCTG). The term OCTG covers hollow steel products of circular cross section intended for use in the drilling of oil or gas. It concludes oil well casing, tubing and drill pipe of carbon or alloy steel, whether welded or seamless, to either American Petroleum Institute (API) or non-API specifications (such as proprietary) as currently provided for in the Tariff Schedules of the United States Annotated (TSUSA) items 610.3216, 610.3219, 610.3233, 610.3242, 610.3243, 610.3249, 610.3252, 610.3254, 610.3256, 610.3258, 610.3262, 610.3264, 610.3721, 610.3722, 610.3751, 610.3925, 610.3935, 610.4025, 610.4035, 610.4225, 610.4235, 610.4325, 610.4335, 610.4942, 610.4944, 610.4946, 610.4954, 610.4955, 610.4956, 610.4957, 610.4966, 610.4967, 610.4968, 610.4969, 610.4970, 610.5221, 610.5222, 610.5226, 610.5234, 610.5240, 610.5242, 610.5243, and 610.5244.

This investigation includes OCTG that are finished and unfinished.

This investigation covers the period from February 1 to July 31, 1985.

Fair Value Comparisons

To determine whether sales of the subject merchandise in the United States were made at less than fair value, we compared the United States price to the foreign market value.

United States Price

As provided in section 772(b) of the Act, we used the purchase price of the subject merchandise to represent the United States price because the merchandise was sold to unrelated U.S. purchasers prior to its importation into the United States.

We calculated the purchase price for Dalsid based on the C.I.F., duty paid, price to unrelated U.S. purchasers. We made deductions for port charges, inland freight, brokerage, duties, wharfage, marine insurance and ocean freight costs incurred in delivering the product to the United States.

Foreign Market Value

We determined that there were insufficient sales of OCTG in the home market for purposes of determining foreign market value. Therefore, we looked to third-country sales as the basis of comparison. We found that Bolivia and Canada were the third-country markets with sales of merchandise at the greatest degree of similarity and largest volumes to which Dalsid sold such or similar merchandise. We have based such or similar product

groupings on advice from Department of Commerce steel experts.

Petitioners alleged that the sales to third countries were made at prices below the cost of production. We examined production costs, inlcuding materials, labor and general expenses as reported in the response. In computing costs of production, we used actual cost for fiscal year 1984 based on the adjusted standard costs rather than 1985 standard costs, since the 1985 standard costs were implemented during the last days of the period of investigation and it was the 1984 standards that were in effect for virtually the entire period. Fixed overhead was adjusted to reflect depreciation expense indexed on a monthly rather than year-end basis.

Selling, general and administrative expenses (SG&A) were adjusted to include all financial effects except primary indexation of sales and non-operating income from investments. Imputed credit expense was included in SG&A expense after deducting a portion of the interest expense attributable to the accounts receivable, which portion was calculated on the basis of total trade receivables to total assets.

In comparing the cost of production to third county sales, we converted Argentine currency to U.S. dollars using the certified exchange rate in effect on the date of third country sale. We found that all such or similar merchandise sold to Bolivia and Canada was sold at prices below the cost of production over an extended period of time, in substantial quantities, and at prices that did not permit recovery of all costs within a reasonable period of time in the normal course of trade. Therefore, we disregarded these sales in our analysis in accordance with section 773(b) of the Act since there were insufficient sales at or above cost of production. Instead, we used constructed value to determine foreign market value. In accordance with section 773(e) of the Act, we calculated constructed value by adding the costs of materials, fabrication, SG&A expenses, as described above, and profit. We used the actual SG&A expenses since they exceeded the statutory minimum of ten percent. We used the statutory minimum of eight percent for profit prescribed in section 773(e)(1)(B) of the Act, since actual profit was less than eight percent of the sum of manufacturing costs and SG&A expenses. We added U.S. packing costs. We made an adjustment for differences in circumstances of sale for credit terms in accordance with § 353.15 of our regulations.

In calculating foreign market value, we made currency conversions from Argentina australs to U.S. dollars using certified exchange rates in accordance with section 353.56(a)(1) of our regulations.

Verification

We vertified the information used in making our final determination in accordance with section 776(a) of the Act. We used standard verification procedures, including examination of relevant sales and financial records of the company.

Petitioners' Comments

Comment 1. Petitioners assert that there are discrepancies between the U.S. sales prices reported by Dalsid to the Department and certain data submitted by respondent relative to its U.S. sales such as the customs duty reported in the response and commissions.

DOC Response. We have verified the information submitted relative to Dalsid's U.S. sales and found the information to be complete and accurate. Therefore, we have relied on that data in our determination.

Comment 2. Petitioners argue that Dalsid did not sell the "green shell," which is reported in the response, prior to its importation. This assertion is based on the following facts: (1) Some of the pipe has not been delivered to the U.S. customer and the long period between the contract and delivery is unusual in the trade and (2) some of this pipe has been offered to another U.S. customer.

DOC Response. We verified all aspects of the reported sales of "green shell." In the course of the verification we reviewed the contract, export and import documentation and other relevant documentation. The subject pipe has been shipped into the United States. It is being stored for the account of the customer identified by Dalsid with storage costs accruing to the customer's account. The customer also paid U.S. inland freight costs. Title has transferred with respect to some of the reported sales. Title has not transferred on some of the pipe because of a downturn in the oil industry. However, the contractual obligation is fixed. It is correct that Dalsid offered some of this pipe to another U.S. customer. However, if any pipe had been delivered to the second customer, Dalsid would have been obligated to replace that pipe for delivery to the original customer on the same terms. The proposed sale to the second customer was not completed. Based on the foregoing, we have treated the sales of "green shell" as sales which were made during the period of investigation and completed prior to importation.

Comment 3. Petitioners argue that, since Dalsid has not provided data quantifying adjustments for differences in physical characteristics between "green shell" and finished OCTG which was sold to third countries, the Department should assume that the "green shell" is identical to the finished OCTG.

DOC Response. Since we did not use third country prices as our basis of comparison, the issue is moot.

Comment 4. Petitioners claim that Dalsid has failed to provide certain necessary cost of production data, including product-specific cost data and meaningful explanations of allocation methods used to develop cost.

DOC Response. We disagree. Product-specific cost data were provided in the January 31, 1986 submission. Explanations of allocation methodologies were obtained during verification and described in the verification report.

Comment 5. Petitioners argue that meaningful participation by petitioners was precluded by Dalsid's failure to provide requested information which tied submitted cost information to the financial statements.

DOC Response. As the submission was prepared on a current cost basis, which is the Department's methodology for accounting for the effects of inflation on costs, the submitted costs were not traceable through the company's product cost accounting to the financial statements. However, during verification the submission was reconciled to the general ledger, disbursement records, and source documents.

Comment 6. Petitioners state that details of Dalsid's allocation of financial expenses to cost of production must be available under administrative protective order, so that the petitioners can comment on Dalsid's allocation of financial expenses to SG&A expense.

DOC Response. The petitioners have received a full narrative description which identifies discrete categories of financial expenses. These are sufficient to allow petitioners to comment on the appropriate classification of these expenses for purposes of our calculations.

Comment 7. Petitioners assert that the Plan Austral has not altered significantly the inflationary adjustments that need to be made to Dalsid's costs.

DOC Response. Because the submission was prepared on a current cost basis, we believe that the submitted costs adequately took into account inflation.

Comment 8. Petitioners argue that it is unclear whether the respondent's current cost methodology represented costs of material imputs at the time of purchase or at time of actual usage. Consequently, petitioners cannot assess whether the full effects of inflation have been captured. In addition, petitioners are unable to determine if Dalsid's current cost methodology adjusts for the carrying costs of inventory and materials inputs.

DOC Response. The submitted current costs for materials were calculated by using actual costs of purchases in the month of shipment of the OCTG. Inventory carrying costs were effectively included in the submission through allocation of financing expenses and manufacturing overhead.

Comment 9. Petitioners contend that in periods of high inflation, Dalsid's use of standard material usage and scrap recovery rates may obscure the true costs of production.

DOC Response. For the submission only standard material usage and scrap recovery rates, both of which approximate the actual expenses of the company, were used. As the actual costs for materials, for scrap and for the credits for scrap recovery were used, inflation has been taken into account.

Comment 10. Tax credits on Dalsid's sales to third country markets do not offset the value added tax (VAT) that Dalsid must pay on its input materials. Therefore, the VAT on raw materials should be included in the cost of production.

DOC Response. We disagree, since the company is reimbursed for the VAT paid on raw materials which are used for exported finished goods.

Comment 11. Petitioners argue that the Department must ensure that Dalsid does not understate its costs by valuing its scrap at market value. The per unit value of scrap must be reduced by Dalsid's cost of reclaiming and reprocessing its scrap or the credit will be overstated.

DOC Response. The process of reclaiming and reprocessing scrap is part of the normal operations of OCTG production and therefore is included in the cost of manufacturing.

Comment 12. Petitioners argue that the Department has not chosen the most suitable third-country sales for comparison with Dalsid's U.S. sales. They believe Bolivian sales would be more comparable than Colombian for "green shell" comparisons.

DOC Response. We have reviewed the submitted data and determined that sales to Bolivia constitute sales of the most comparable OCTG sold in adequate commercial quantities to a free market. Therefore, we have made comparisons with these sales.

Comment 13. Petitioners argue that because of the recent finding of Revenue Canada that Argentine casing was being sold at the time in question at approximately 40 percent below fair value, those sales may not present a fair basis for comparison. Other third-country sales would, therefore, form a more appropriate basis for comparison.

DOC Response. Since we found the sales to Canada were at less than cost, we used constructed value as our basis of comparison. Therefore, the issue is moot.

Comment 14. Petitioners contend that the methodology described in Dalsid's questionnaire response to calculate the credit adjustment on third-country sales appears to be inappropriate. They contend that the interest rate found at verification should be used to calculate the third-country credit adjustment. In addition, they claim that the interest rate used to calculate credit costs on U.S. sales, by Dalsid, is totally inappropriate.

DOC Response. We based our credit calculations on actual interest rates charged to Dalsid for equivalent borrowings and the days outstanding, which were verified.

Respondent's Comments

Comment 1. Respondent contends that Dalsid's sale of green shell is a purchase price sale made during the period of investigation.

DOC Response. See our response to Petitioners' Comment 2.

Comment 2. Respondent contends that its cost information is complete.

DOC Response. We believe that the submitted cost data and the cost data obtained during verification were sufficient to be used for purposes of our final determination.

Comment 3. Respondent argues that green shell is not similar merchandise to finished OCTG.

DOC Response. We disagree. Based on analysis performed by Department of Commerce industry experts, we have determined that green shell is similar to certain grades of finished OCTG. We compared the green shell sales to sales of similar OCTG to Bolivia with adjustments for differences in physical characteristics. In reaching our conclusion, we determined that green shell is made of essentially the same component materials with variations in proportions of those materials, can be used for the same purposes as finished OCTG, is commercially interchangeable with finished OCTG, and that the further processing is done at the option of the purchaser.

Comment 4. Respondent argues that if the Department is going to compare green shell with Dalsid's finished OCTG, it should be compared with J-55 grade, because it is more similar than any other finished OCTG based on physical characteristics, potential uses, and commercial value.

DOC Response. We agree that J-55 is the most similar grade to the green shell which was sold to the United States. There were insufficient sales of this grade in comparable sizes to free market third countries during the period of investigation. Therefore, we chose sales of N-80, the next most comparable grade, as our basis of comparison. We found that these sales were made at prices which were below the cost of production.

Comment 5. Respondent claims that N-80 grade cannot be considered similar to green shell because it does not have facilities to upgrade the green shell to that grade. Dalsid produces N-80 by another process.

DOC Response. Based on advice from our commodity experts, we have determined that N-80 meets the criteria for merchandise similar to green shell. The adjustments for differences in physical characteristics are based on direct manufacturing costs incurred; therefore, respondent's ability to upgrade the green shell is irrelevant.

Comment 6. Respondent argues that in making price-to-price comparisons, we should use the most comparable products sold to third countries.

DOC Response. See our responses to Petitioners' Comments 12 and 13 and Respondent's Comment 4.

Comment 7. Respondent argues that the Department was correct in its preliminary finding that critical circumstances do no exist.

DOC Response. Since this determination is negative, the issue is moot.

Comment 8. Respondent argues that in evaluating whether critical circumstances exist, we should not consider the March-June period in determining whether there were massive imports over a relatively short period. Respondent argues that there were no imports during this period because of the disruption in the market caused by a previous antidumping duty investigation of OCTG from Argentina. That investigation was terminated when the ITC found no injury on May 22, 1985 (50 FR 21147).

DOC Response. Since this determination is negative, the issue is moot.

Final Determination of Critical Circumstances

Since this determination is negative, the issuse of whether critical circumstances exist is moot.

Discontinuance of Suspension of Liquidation

In accordance with section 735(c)(2)(A) of the Act, we are directing the United States Customs Service to discountinue the suspension of liqudation for all entries of OCTG from Argentina that were entered, withdrawn from warehouse, for consumption, on or after January 27, 1986. Accordingly all bonds should be cancelled and estimated antidumping duties deposited should be refunded.

ITC Notification

In accordance with section 735(d) of the Act, we will notify the ITC of our determination.

This determination is published pursuant to section 735(d) of the Act (19 U.S.C. 1673(d)).

Paul Freedenberg,

Assistant Secretary for Trade Administration.

[FR Doc. 86-12610 Filed 6-2-86; 9:38 am]

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Tehran American School Claim Act of 1985. (May 29, 1986; 100 Stat. 509; 1 page) Price: $1.00